Table of Contents

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Chartered

REPORT ON EXAMINATION OF THE EFFECTIVENESS OF INTERNAL CONTROLS OVER FINANCIAL REPORTING

OF

D.C. CHARTERED HEALTH PLAN, INC.

PERFORMED FOR

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

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Meeting the Toughest Challenges.
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Table of Contents

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Table of Contents

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Mr. Robert T. Maruca
Senior Deputy Director
Department of Health
Medical Assistance Administration
Government of the District of Columbia

We have examined the effectiveness of D. C. Chartered Health Plan, Inc.'s (CHARTERED) internal control over financial reporting as of December 31, 2005, based on the Committee of Sponsoring Organizations of the Treadway Commission's Internal Control Integrated Framework (COSO Framework). CHARTERED's management is responsible for maintaining effective internal control over financial reporting. Our responsibility is to express an opinion on the effectiveness of internal control based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included obtaining an understanding of internal control over financial reporting, testing, and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

Because of inherent limitations in any internal control, misstatements due to error or fraud may occur and not be detected. Also, projections of any evaluation of internal control over financial reporting to future periods are subject to the risk that the internal control may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our examination disclosed a number of material internal control weaknesses that are described in the accompanying text to this report. A material weakness is a condition that precludes the entity's internal control from providing reasonable assurance that material misstatements in the financial statements will be prevented or detected on a timely basis.

In our opinion, because of the effect of the material weaknesses described in the accompanying text to this report on the achievement of the objectives of the control criteria, CHARTERED has not maintained effective internal control over financial reporting as of December 31, 2005, based on the COSO Framework.

This report is intended solely for the information and use of the Government of the District of Columbia and is not intended to be and should not be used by anyone other than that specified party.

Milligan + Company, LLC

April 2, 2007

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SECTION I: Description of Chartered Health Plan, Inc

Chartered Health Plan, Inc. (CHARTERED), a wholly owned subsidiary of DC Healthcare Systems, Inc, is a private sector Health Maintenance Organization that provides managed health care services including health education and awareness, preventative and health maintenance services, and treatment for diseases and conditions. The company was created through incorporation in 1986 under the laws of the District of Columbia. CHARTERED earned 93% of its 2005 revenue from a contract with the Government of the District of Columbia's Department of Health to provide health services to Medicaid recipients receiving Temporary Benefits for Needy Family (TBNF) benefits. CHARTERED provides services to over 38,000 eligible members. CHARTERED fulfills it's contract requirements through a large network of approximately 1400 providers, 7 hospitals, and 54 primary care sites, which includes Chartered Family Health Center, Inc, another wholly owned subsidiary of DC Healthcare Systems, Inc. The contract with the district also requires CHARTERED to provide transportation services to Medicaid recipients; CHARTERED uses Rapid Transit, Inc., another wholly owned subsidiary of DC Healthcare Systems, Inc. to provide these services.

SECTION II: Material Weaknesses

For purposes of this report, a material weakness is a condition that precludes the entity's internal control from providing reasonable assurance that material misstatements in the financial statements will be prevented or detected on a timely basis.

SECTION II

Material Weaknesses

II-I Transactions with related parties are not supported by adequate documentation.

During calendar year 2005, CHARTERED expended approximately $12.2 million of its total $92.7 million Medicaid contract operating expenses on transactions with businesses owned and controlled by the owner of D.C. Healthcare Systems, Inc., CHARTERED's parent company. No documentation was provided to evidence that these contracts were negotiated at arms-length and some of the payments appear to exceed amounts paid to unrelated parties for similar services.

For instance, approximately $5.5 million was paid to Chartered Family Health Center for services at capitation rates that were more than double the rates paid to other providers for the same contracted services. Also, $1,800,000 was paid to its parent company for consulting services which were said to be provided by CHARTERED's owner and another individual. However, we did not find adequate evidence to support these payments and they were not paid in accordance with the contracted terms.

Finally, amounts paid for transportation services, rent, and other consulting and professional services were not supported by adequate evidence that the services were actually compensated at fair value.

In addition to the concern relating to fair compensation, there is an inherent concern that related parties are not monitored and held to the same or higher contract compliance standards that is expected of unrelated parties. We noted no evidence on some of the contracts that CHARTERED monitored its affiliates' performances at levels that are adequate to ensure contract compliance.

Recommendation:

We recommend that all contracts with affiliates' for costs that are reimbursed directly or indirectly by third parties be reviewed and approved by an appropriate party who is independent of CHARTERED's owners and management. Also, an independent party should be engaged to monitor the contract compliance of affiliated vendors.

II-II CHARTERED's control environment and risk assessment process needs to be improved.

The first major internal control component described by the COSO report is "Control Environment". Maintaining an effective Control Environment involves a number of conditions in the organization that ensures an attitude of discipline and commitment throughout the organization. Such conditions may include:

- ❖ A functional and independent board of directors
- ❖ An audit committee
- ❖ An internal audit function
- ❖ A functional ethics policy

We noted that many of the conditions required for an adequate internal control environment are not evidenced at CHARTERED. For instance, we were informed that the chairman personally reviews and approves some transactions after management's pre-approval. Such activity could lead to corporate policy or controls being overridden. Also, there is no functional audit committee or ethics policy.

Recommendation:

We recommend that CHARTER's board of directors initiate actions to improve its internal control environment. Such actions may include the following:

- ❖ Creation of a functional audit committee that selects and manages the external auditors and provides supervision and guidance to an internal audit function.
- ❖ Develop and enforce an effective ethics policy that requires annual certifications from key members of management.
- ❖ Ensure that all internal and external audit findings are addressed on a timely basis.
- ❖ Establish policy to ensure that adequate internal control policy is implemented, the board of directors is not permitted to override policy, and establish a whistle-blowers hotline.

II-III CHARTERED was unable to demonstrate that it has adequate controls over its IT Functions.

As a part of our assessment of CHARTERED's internal controls we requested its management to complete an ***Information systems capabilities assessment for managed care organizations***, which is a questionnaire recommended by the Center for Medicare and Medicaid Services (CMS). Completion of this questionnaire is one of the first steps that CMS recommends as a part of an external assessment of an MCO's internal control systems. The form is designed for the MCO to document its key IT applications, infrastructure, and security over its computer systems. Although we requested this form on several occasions and were told that it was forthcoming, when the form was received, it was only partially completed. We did not receive any responses to our questions on the partially completed form. Additionally, during our review of the IT systems the individual with overall responsibility for the system resigned.

CHARTERED's inability or unwillingness to provide this data or equivalent data represents an inability to demonstrate adequate internal controls over its IT systems.

In addition, we were able to identify a number of internal control deficiencies which collectively represent a material weakness. These deficiencies are noted in appendix A to this report.

Recommendation:

We recommend that CHARTERED obtain the resources and expertise to implement the recommendations in appendix A of this report.

SECTION III: Reportable Conditions

For purposes of this report, a reportable condition is a matter coming to our attention that, in our judgment, should be communicated to because they represent significant deficiencies in the design or operation of internal control, which could adversely affect the organization's ability to initiate, record, process, and report financial data consistent with the assertions of management in the financial statements.

SECTION III

Reportable Conditions

General Conditions

III-I No SAS 70 report is obtained from service centers responsible for processing claims and encounter data.

CHARTERED has a significant portion of its claims and encounter data submitted to and partially adjudicated by two different service processors. As such, the internal controls over the receipt, processing, and summarization of the data received by those service processors reside at those service processors' locations. In addition, payroll processing is outsourced to a service processor whose responsibilities include generating various reports which are used to record payroll activities in the general ledger.

CHARTERED has no documented procedures in place to ensure that the internal controls over the processing of their data by the service processors are adequately designed and functioning.

Recommendation:

We recommend that CHARTERED implement a process to ensure that the controls at all service processors who process data for it has adequate internal controls in place. At a minimum, CHARTERED should require all service processors obtain a SAS 70 audit of their internal controls design and operating effectiveness.

III-II CHARTERED does not have a formalized policy to fairly allocate administrative support costs to affiliates.

During discussions with management, we noted there is no formal method for allocating employee time for those employees who are providing services to CHARTERED's affiliates, D.C. Chartered Family Health Center and RapidTrans, Inc. CHARTERED provides human resources and payroll support to these affiliates. According to management, approximately 30-35 percent of CHARTERED's Human Resources Department's hours are expended on the affiliates' activities. Based on employee wages, benefits, and payroll tax expense noted on the fiscal year 2005 trial balance, Human Resources Department expenses totaled $425,000, of which, 30 percent equals $127,500. CHARTERED's management noted $45,000 were recorded for the Affiliates for administrative services provided. Management did not provide a basis for how the $45,000 was determined prior to the conclusion of our fieldwork. Based on our simple calculation above, which excluded payroll support related hours, there is a shortfall on the reimbursement of CHARTERED's administrative expense of at least $82,500.

Additionally, a review of timesheets noted that timesheets did not have the ability to track employee time by company serviced.

Recommendation:

We recommend that CHARTERED establish and implement an acceptable indirect cost allocation plan for reimbursement of administrative services incurred for services provided to affiliates.

Claims and Encounter Data

III – III Prepare and document formalized procedures to minimize fraud and inaccurate claims and encounter reporting by providers.

Inherent in the Medicaid industry is a high risk of waste, fraud, and abuse; especially as it relates to payments to providers. Most health care insurance companies, such as the Blues, who compete in the market place primarily based on the cost of their product makes significant investments in initiatives to minimize these abuses. We were informed by one of the major Blues that they receive a return of $5 to $10 for every dollar spent on programs to minimize fraud and abuse.

Although CHARTERED does utilize an Ingenix anti-fraud software application to review and analyze claim data, we believe that their fraud and abuse prevention initiatives could be stronger.

Recommendation

Internal desk reviews of selected services and provider site audits are required to prevent fraud and we recommend that the Plan conduct such audits periodically for all providers.

III – IV Prepare and document formal procedures for extraction and consistent reporting of claims payments and encounter data

As a part of our testing of claims and encounter data, we requested a data file consisting of specific fields from the data base containing all claims paid in 2005 and all encounters in 2005. The file was requested to perform an analysis on the accuracy, completeness, validity, and occurrence of the data. We noted that CHARTERED had great difficulty providing an accurate, complete, and a consistent data file. In response to our request, we received a total of four data files from the Senior Information Systems staff. See Table 1.

The first file was unable to be analyzed due to an exportation error. The second claims data file, consisting of 707,059 records, $51,454,414 paid claims, and 36,883 unique members did not include transactions voided and reversed. The third claims data file requested consisting of 772,028 records, $51,531,409 paid claims, and 36,942 unique members did not include the field "Batch_Entry_ID", a field identifying the general ledger account(s) the individual claim is contained in. The fourth file requested contained

879,753 records, $51,562,394 claims paid, and 36,945 unique members. This file contained the "Batch_Entry_ID" field, but also an additional field "Claim ID" added by the discretion of the programmer. We called a meeting with all CHARTERED personnel involved in the data file extraction to gain an understanding of the problem in pulling consistent files. CHARTERED management offered the following explanations for the differences in files; two different programmers basing the criteria for the query on different assumptions and that the extraction was pulled from two different data sources (MHC and a data warehouse). Millco preformed a comparative analysis on the files received and noted that the results of financial and non-financial data did not change by a material amount.

Table 1 – Summary of Fiscal Year 2005 Paid Claims Data Files Received

Version of File	1st	2nd	3rd	4th
Number of Records	Unable to Determine Accurately	707,059	772,028	879,753
Dollar Value of Claims Paid	Unable to Determine Accurately	$51,454,414	$51,531,409	$51,562,394
Number of Members	Unable to Determine Accurately	36,883	36,942	36,945

The inconsistency in the extraction of the data file raises concerns. The fact that the first file was pulled using an incorrect field separator is an indication of personnel without the appropriate expertise is performing critical processes. Secondly, the inconsistency in presentation of the claims information indicates an internal control weakness in the control environment being that formal procedures have not been developed.

Recommendation:

CHARTERED should develop and implement formal policy and procedures for the extraction of reports commonly used in normal business practice and reporting to external parties. Specifically, the criteria to extract the total amount of claims incurred during a given year and the number of encounters for a given year should be standard for all people responsible for extracting such reports from financial and non-financial systems. The information included in an extraction of a report should include all informational data fields necessary to trace to supporting documentation and summarization reports. The extraction should be executed on the same data store (e.g. Database or Data Warehouse). The information reported through the extraction should be complete and consistent regardless of who pulled it and when it was pulled.

III – V Controls should be strengthened over payments to pharmacies.

For year 2005, the total pharmacy expenditures included in CHARTERED's healthcare cost was approximately $9,400,000. CHARTERED makes bi-weekly payments to Caremark, the prescription drug benefit administrator. The bi-weekly payments take the form of wire transfers and the bi-weekly amount is based on a request that is faxed from

Caremark to CHARTERED. Caremark subsequently provides CHARTERED with a detailed bi-weekly report and monthly summary report. However, CHARTERED does not agree the bi-weekly wire transfer payments to the detailed monthly report. In addition, the cost amount included in the detailed monthly report is not confirmed to the agreed upon rates in the contract.

Recommendation

We recommend that CHARTERED agree the bi-weekly wire transfer payment amounts to the detailed monthly report for all payments made. In addition, we recommend that CHARTERED confirm the rates used in payment processing to the agreed upon rates in the contract. We also recommend that CHARTERED implement procedures to ensure that Caremark maintain adequate internal control over the drug benefit administrative process.

III - VI Certain costs are paid for and paid to Chartered Health Family Center that are charged to healthcare cost without supporting documentation.

The Chartered Health Family Center (CHFC) is a wholly owned subsidiary of DC Healthcare Systems Inc, which is the parent company of CHARTERED. CHARTERED pays CHFC a capitation rate of $49.44 per member per month compared to the lowest rate of $12.50 and the highest rate of $21.50 paid to other primary care centers. Documentation supporting the higher rate of $49.44 was requested but has not been received.

Other costs are absorbed by CHARTERED applicable to CHFC: in addition to the capitation rate paid to CHFC, CHARTERED also incurs other CHFC expenses (i.e.: depreciation of leasehold improvements and medical equipment) which are then included in CHARTERED's total healthcare costs.

Recommendation

We recommend that CHARTERED complete a cost benefit analysis of the capitation rate paid to CHFC and document the basis for the higher rate. We also recommend that CHARTERED identify expenses (incurred by CHARTERED) that are related to CHFC and adjust the capitation rate or arrange for reimbursement from CHFC.

III – VII The number of enrollees in sub-capitation arrangements with PCP differ from the number of enrollees in sub-capitation arrangements with others.

CHARTERED has sub-capitation arrangements with non-PCP vendors; for example, vision, dental care, and re-insurance. The membership number used in the monthly capitation payments to these vendors should relate to the total membership in CHARTERED. We were unable to reconcile the total number of members in sub-capitation arrangements to the total membership number. Documentation supporting the

determination of the monthly membership number used in sub-capitation calculations was requested but has not provided.

Recommendation

We recommend that CHARTERED confirm the number of enrollees in all sub-capitation arrangements.

Payroll and Human Resources

III – VIII Improve controls over Payroll and Human Resources Departments.

During our review of CHARTERED Payroll and Human Resources Departments we noted the following:

- There is no system in place to verify the accuracy of the information entered into the human resources system on a regular basis. No secondary review is completed once an employee is setup in the Human Resources database. In order to maintain effective control and accountability over the Human Resources data, CHARTERED must establish procedures to ensure that all critical information is entered accurately and that any discrepancies are discovered in a timely manner.
- No formal written Human Resources policies and procedural manual was developed. A formal Human Resources policy and procedural manual will ensure, in the event of employee losses, an employee with the appropriate background will be able to perform HR functions with minimal loss of efficiency in the department.
- Management was surprised by human resources personnel access to the payroll system. Management indicated that human resources staff does not have access to payroll system; however, we were able to observe a human resources personnel login into the payroll system. Our requests for a system generated user list for the human resources or payroll system were not received prior to the end of our fieldwork; therefore, we were unable to confirm the level of access human resources personnel maintained.
- Payroll checks are received from the payroll processor by the same employee responsible for submitting payroll data to the payroll processor. Adequate segregation of duties requires employees with responsibilities for processing payroll should be segregated from employees with the responsibility of distributing payroll checks. Proper segregation of duties will reduce the risk that fraud or errors will occur without being detected within a reasonable period of time.
- Documentation to support supervisor review of payroll expenses was not maintained.
- Authorized wire requests are not maintained at CHARTERED. Accounting records should be maintained in centralized location to ensure the records can be retrieved in a timely manor.

Recommendation:

CHARTERED should conduct a formal review of its policies and procedures to detect any deficiencies and/ or violations of its policies. Any noted deficiencies should be corrected within a reasonable period of time.

Cash Disbursements

III – IX Improve documentation and support over cash disbursements.

During our testing of a sample of 40 expense transactions we noted the following:

- No support received for 5 expenses;
- 31 journal entry batch listings were not received;
- 10 check request forms were not properly approved by the required parties;
- No canceled check was provided for 2 expenses;
- 2 expenses were not properly post to G/L;
- 1 check request did not properly note invoice was canceled;

Recommendation:

CHARTERED should take the necessary steps to ensure established policies and procedures are followed as designed.

APPENDIX – A

Reportable Conditions Relating to Information Technology

Findings	Risk	Recommendation
Control Objective 1: Though CHARTERED has implemented security related personnel policies, we found instances where policies relating to the performance of background investigations, contacting references, and terminating employees were not complied with. Specifically, we found the following: • Background checks were not completed for six (6) out of ten (10) sampled new hires. • Reference checks were not completed for six (6) out of ten (10) sampled new hires. • Exit meetings were not documented for six (6) out of ten (10) sampled terminated employees. • There was no documentation of the return of company property for six (6) out of ten (10) sampled terminated employees.	Policies related to personnel actions, such as hiring and termination, are important factors for information security. If personnel policies are not adequate, an entity runs the risk of (1) hiring unqualified or untrustworthy individuals, (2) providing terminated employees opportunities to sabotage or otherwise impair entity operations or assets, (3) failing to detect continuing unauthorized employee actions.	CHARTERED should ensure that policies relating to hiring and termination of employees and contractors are fully implemented.

Findings	Risk	Recommendation
Control Objective 2: Though CHARTERED considers all data as high risk, there was no documentation to support how that determination was made. In addition, there was not consistency in the protection of all CHARTERED data in line with the level of risk.	Classifying data and resources according to their sensitivity and criticality will ensure that resources are protected adequately with the most cost-effective controls. This will ensure that the most critical resources are subject to the strongest protective controls.	CHARTERED should establish and document classification of resources and related criteria according to their levels of sensitivity and criticality.
Control Objective 3: The authorization, documentation, and monitoring of access to CHARTERED's computerized applications, Network and Medicaid data as well as procedures to sharing and properly disposing of data did not provide maximum security. Specifically, we noted the following: • Management could not provide evidence to show that accesses to CHARTERED's systems (Network, MHC, Oracle, UNIX, and Remote) are reviewed periodically. • Though CHARTERED's hard drives are required to be destroyed prior to disposal, there are no clear procedures on how to clear sensitive data and software contained on such hard drives. CHARTERED presently keeps old hard drives in a locked cabinet. • CHARTERED does not have password control guidelines that spell out the minimum password requirements for CHARTERED systems. • Password security parameters are not enforced at the MHC application level.	Lack of periodic review of accesses to CHARTERED systems increases the risk that unnecessary and terminated accesses will remain on the systems. The existence of unnecessary and terminated accesses could allow unauthorized accesses. Setting the Windows account lockout duration to any value apart from 0 will enable unauthorized users who are locked out to wait for the lockout duration to expire and then retry. When the value is set to 0, the Administrator is required to re-enable the account before account lockout reset has expired. Also, disabling password complexity and network force logoff hours expire could increase the risk of unauthorized access to the network. If sensitive information is not fully cleared from hard drives, it may be recovered and inappropriately used or disclosed by individuals who have access to them. Thus this increases the risk of exposure of highly sensitive data and software stored on stored hard drives.	CHARTERED management should implement controls to ensure that accesses to all systems are reviewed periodically and documented. The review should result in the deletion of terminated and unneeded accesses. The following Windows settings are recommended: Password complexity requirements should be enabled; Account lockout duration should be set to 0 minutes; Network security: Force Logoff when hours expire should be enabled. CHARTERED should put procedures in place to clear sensitive information and software from computer hard drives when they are disposed of or transferred to another use. The responsibility for clearing information should be clearly assigned and standard forms or a log should be used to document that all discarded or transferred items are examined for sensitive information and that this

Findings	Risk	Recommendation
• 2 out of the 60 terminated employees still had active access to the MHC application. • 17 out of 60 terminated employees still had active access to the UNIX system. The accesses in MHC were deleted. • 2 out of the 60 terminated employees still had active access to the Sungard General Ledger System. • We found that the following Windows Domain settings were not consistent with best practice: • Password complexity requirements are not enforced (Recommendation – Should be enabled); • Account lockout duration is set to 60 minutes (Recommended – 0 Minutes); • Network security: Force Logoff when hours expire is disabled (Recommendation – Should be enabled). • 4 employees had not logged on to the network for at least 65 days. Additionally, 3 systems (FAX UM, FASSERVER, and exchsrv) have not logged on for a considerable amount of time. • Audit trail of the Oracle database system is not maintained	The absence of adequate audit trails could limit CHARTERED's ability to monitor compliance with security policies and investigate security incidents in Oracle.	information is cleared before the items are released. The Oracle audit trail option should be activated to log user activity and changes to critical master files and tables. The logs should be reviewed periodically by the System Administrator.
Control Objective 4:		

Findings	Risk	Recommendation
CHARTERED's security policies and controls for ensuring the security of platform configurations and proper patch management of operating systems do not provide maximum security. We found that: • CHARTERED does not have baseline configuration guidelines for the UNIX operating system, Universe database, Oracle database, and Windows systems. • CHARTERED has not formally implemented patch management practices for Oracle as per the patch management policy. The current Oracle database version (8i) is not supported hence critical patches are not received from the vendor.	The use of well-written, standardized baseline configuration can markedly reduce the vulnerability of exposure of IT systems. Its absence could result in the lack of baseline level of security to protect against common and dangerous local and remote threats and a consistent approach to securing systems. This could also result in significant delays in researching and developing appropriate security configurations for installed IT systems. By using unsupported Oracle system, critical security patches may not be available from the vendor to remedy potential security vulnerabilities.	CHARTERED should develop baseline configurations for all the operating systems and database systems. These include UNIX, Windows, UNIVERSE, and Oracle. CHARTERED should consider upgrading the Oracle database to a version that is supported by the vendor.
Control Objective 6: CHARTERED's controls for authorizing, documenting, testing, and approving Medicaid application and related systems software development and maintenance activities had the following weaknesses: • CHARTERED has currently not developed a policy to include Internal Audit and/ or Security Management in the MHC software release implementation process to ensure that the new enhancements contain adequate internal controls. • Millco was unable to obtain evidence that the current review process associated with the removal of	Failure to include the internal audit or security management functions in the application software release implementation process increases the risk that potential security vulnerabilities in the new release may not be detected prior to implementation. Failure to formalize and document removal of unauthorized software form CHARTERED employees' desktops makes it impossible to prove that the control is being implemented. This introduces some level of risk given the highly sensitive nature of Medicaid data stored on CHARTERED systems.	CHARTERED should develop a policy to require Internal Audit or Security Management in the MHC software release implementation process. CHARTERED should formalize and document the current unauthorized software review process to confirm that all software identified are indeed removed from employees' desktops.

Findings	Risk	Recommendation
unauthorized software from individuals' desktops is formalized or documented.		
Control Objective 7: CHARTERED's configuration of the UNIX operating system, UNIVERSE database and the ORACLE database that store MHC claims data had the following weaknesses: • Password controls are not enforced at the Oracle database level. CHARTERED password controls are enforced at the network level. • An unjustified user account was assigned a default tablespace of SYSTEM in the DBA_USERS view. The account has since been deleted. • The UNIX system is not running a trusted mode. • Two root identification codes were assigned on the UNIX system. • 93 duplicate accounts existed on the UNIX system. CHARTERED agreed to delete them. • An unjustified generic account existed on the UNIX system. CHARTERED agreed to delete the account. • Password is not enforced at the UNIVERSE database and UNIX operating system levels. • 5 R commands were running on the UNIX system.	• Oracle password security is critical in ensuring the confidentiality and integrity of data stored in the database. • If a default tablespace is not specified when creating a user, the default tablespace is the SYSTEM tablespace and this could create security and data management risk. • A trusted HP-UX system maintains 2 password files: /etc/passwd and Tcb/files/auth/ directory. HP-UX Trusted Mode enables support for shadow passwords and is a prerequisite for enabling password aging and kernel-level auditing. Without shadow passwords, an intruder could use any user's account to obtain hashed passwords and use crack or similar utilities to find easily guessed passwords. If the Tcb/files/auth/ directory exist, the system is running a trusted mode. If it does not exist, the system is not in trusted mode. • Any account with UID=0 would have superuser privileges on the system. The only superuser account on the system should be root. Multiple UID=0 identification codes increase the risk that users have system access privileges that are not required for their job functions. In addition, unauthorized users who target	The following minimum values are recommended for every oracle user's profile: ➢ SESSIONS_PER_USER limited to one for most users ➢ IDLE_TIME less than 15 to 30 minutes ➢ FAILED_LOGIN_ATTEMPTS = 5 ➢ PASSWORD_GRACE_TIME set to 0 or 1 ➢ PASSWORD_LIFE_TIME set to 35 days or less ➢ PASSWORD_LOCK_TIME set to 500 days or more • Each user should have a tablespace assigned to them. All accounts assigned a default tablespace should be justified. • CHARTERED should consider running a trusted mode given the sensitive nature of the Medicaid data • There should be only one root level identification code defined on the local UNIX server. • Duplicate UIDs should be deleted. • Unjustified generic user identifications should be removed from the password file. • CHARTERED should consider enforcing password controls at the UNIVERSE database and UNIX operating system levels.

Findings	Risk	Recommendation
• A Trivial File Transfer Protocol (TFTP) was running on the UNIX server without a secure option.	privileged identification codes have multiple opportunities to gain root access. • Duplicate UIDs limit accountability on user actions performed while logged, even if the system is logging all events of the users. This increases the risk that unauthorized users will modify or delete files created by another user without being noticed. • Generic user identification codes limit accountability on user action performed while logged in as a generic user, even if the system is logging all events of the generic user. In addition, default generic users, such as the "guest" identification code are normally targeted by intruders attempting to gain access to a system. • The etc/default/security and etc/securetty files allow password parameters to be set for users when running an HP-UX trusted mode. Setting password parameters to reasonable values help discourage brute force password guessing attacks and minimize the risk of unauthorized accesses. • R-commands allow users to run commands on remote machines, login to other machines and copy files between machines. These services are historically risky and a target of attackers because of their weak authentication. For instance r-login does not necessitate the user to provide a user name. The system receiving the r-login lets the user log in without password.	• R-commands should be deleted from the system. • The TFTP (trivial file transfer protocol) should be disabled or should run with the secure option (-s). The -s option turns on socket-level debugging.

Findings	Risk	Recommendation
	• Use of TFTP increases the risk that unauthorized files are transferred across the network. For example, if the /etc/passwd file is transferred across the net, a user could run a cracker program on the password file and obtain unauthorized password. If there is no need to utilize the TFTP then it should be removed from the /etc/inetd.conf file. Otherwise, it should be restricted by invoking the –s option, which restricts its use to a specific directory.	
Control Objective 8: CHARTERED's controls for ensuring that adequate segregation of duties exists between various functions within Medicaid operations had some weakness. Specifically, the Senior Programmer/Unix Administrator currently perform conflicting functions and there is no evidence of an effective review process to mitigate this risk.	Inadequately segregated duties increase the risk that erroneous or fraudulent transactions could be processed; that improper program changes could be implemented; and that computer resources could be damaged or destroyed.	CHARTERED should implement and document a formal review of the activities of the Senior Programmer/Unix Administrator.
Control Objective 10: The following weaknesses were identified in the risk assessment and systems security program of CHARTERED: • CHARTERED has not implemented an independent risk assessment that considers data sensitivity and integrity and the range of risks to the entity's systems and data. • The Information Security Plan does not comply with best practices and the copy provided to us was in draft form and not approved by Management and was not current.	A comprehensive high-level risk assessment is important because it helps make certain that all threats and vulnerabilities are identified and considered; that the greatest risks are identified; and that appropriate decisions are made regarding which risks to accept and which to mitigate through security controls. Without a well designed and approved security plan, security controls may be inadequate; responsibilities may be unclear, misunderstood, and improperly implemented; and controls may be inconsistently applied. Such conditions may lead to insufficient protection of sensitive or critical resources and	CHARTERED should perform and document an independent risk assessment on a regular basis or whenever there is a significant change in its IT environment. The risk assessment should consider data sensitivity and integrity and the range of risks to the entity's systems and data. Further, final risk determinations and related management approvals should be documented and incorporated in the security plan. CHARTERED should document a security plan to cover all major facilities and operations and should be approved by key affected parties. The plan should be reviewed periodically and adjusted to reflect current

Findings	Risk	Recommendation
• CHARTERED could not provide documents to show how recommendations from previous security reviews and audits are tracked, implemented, and corrective actions tested. • CHARTERED has not performed Certification and Accreditation for the MHC application.	disproportionately high expenditures for controls over low-risk resources. Whenever significant weaknesses are identified, the related risks should be reassessed, appropriate corrective actions taken, and follow-up monitoring performed to make certain that corrective actions are effective. This is an important aspect of management's risk management responsibilities. By failing to perform Certification and Accreditation of the MHC application, CHARTERED may not accurately identify and assess information security risks that are essential in determining what controls are required for the MHC application. This could potentially impact the confidentiality and integrity of Medicaid data processed by the application.	conditions and risks and should cover the following areas: (1) Rules of the system / Application rules (2) Training / Specialized training (3) Personnel controls / Personnel security (4) Incident response capability (5) Continuity of support / Contingency planning (6) Technical security / Technical controls (7) System interconnection / Information sharing, and (8) Public access controls. Management should ensure that recommendations from previous security reviews and audits are tracked, implemented, and corrective actions tested. CHARTERED should ensure that Certification and Accreditation of the MHC application is performed at least every 3 years or whenever there is a significant change in the IT operating environment.
Control Objective 11: Though CHARTERED is in the process of developing a comprehensive Business Continuity Plan, the current regularly scheduled processes to support the continuity of operations (data, facilities, or equipment) had the following weaknesses: • CHARTERED has not currently developed and implemented a Business Impact Analysis (BIA) for its Medical Health Care (MHC) application system as part of its contingency planning	If service continuity controls are inadequate, even relatively minor interruptions can result in lost or incorrectly processed data, which can cause financial losses, expensive recovery efforts, and inaccurate or incomplete financial or management information. This is particularly critical given that CHARTERED's Medicaid data is considered highly sensitive.	CHARTERED should develop and implement a comprehensive Business Continuity Plan to include the following: • Business Impact Analysis • Periodic testing of off-site storage backup tapes. • Periodic testing of the disaster recovery plan and adjusting it as appropriate. • Procedures for recovering the MHC application and other systems in order of priority.

Findings	Risk	Recommendation
activities. • CHARTERED has not currently developed and implemented policies and procedures for testing its off-site storage backup tape on a regular basis. • Wet Pipe sprinklers located in the CHARTERED's data center should be capped. • Current MHC application Contingency Plan should be updated to reflect current condition. (i.e. migration from Novel to Windows servers, Identify strategies to recover MHC application, HP Unix OS, Windows OS, Oracle, and Universal data bases). • Current contract or interagency agreement between CHARTERED and Health Center does not exist for an alternate MHC application data processing facility. • The Health Center facility (North East, Washington DC) currently secured as an alternate site for processing data associated with MHC Medicaid Claims system is subject to the potential risk of being affected by the same natural disaster as the main MHC application process facility (North West, Washington DC) because of their close proximity to each other. • The First Federal offsite storage facility (Gaithersburg, Maryland)		• An alternate data processing facility with documented agreement. • Both offsite storage and alternate processing facility should be geographically separated from the CHARTERED primary site. • Regular testing of all critical environmental controls to ensure that they provide adequate controls to critical IT resources in the data center. Specifically, the wet pipe sprinklers in the data center should be capped.

Findings	Risk	Recommendation
currently used for storing backup tapes associated with Medical Health Care (MHC) application, is subject to the potential risk of being affected by the same natural disaster as the main MHC application process facility (Washington, DC) because of their close proximity to each other. • CHARTERED does not inspect the only handheld fire extinguisher in data center on a regular basis.		

REPORT ON REVIEW OF OPERATING EXPENSES

OF

D.C. CHARTERED HEALTH PLAN, INC.

PERFORMED FOR

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

April 2007

MILLIGAN & COMPANY, LLC
Consultants and Certified Public Accountants

Meeting the Toughest Challenges.
Inspiring Confidence.SM

Table of Contents

SECTION I

Introduction:

The legislative power of the Government of the District of Columbia ("the District") is vested in the duly elected officials of the City Council ("the Council") pursuant to its *Home Rule Charter*, as amended. Among other conferred responsibilities, the Council annually determines, via an approved budgetary process, how tax revenues are to be appropriated for various local government services. Although the District is not officially a state under the Federal system of government, it maintains certain "state" functions including sharing in the contributions made by the Federal government's allocation for the provision of Medicaid services for individuals whose family (household) income falls below a predetermined threshold. The Council's committee system includes a Committee of Health ("the Committee") that provides oversight and works with the Council at large to fund various health-related programs and public initiatives on behalf of the District. Oversight of the Medicaid program falls under its jurisdiction.

According to the District's *Annual Medicaid Report*, approximately 135,000 people are beneficiaries of the District's Medicaid Program. As a strategy to implement greater cost efficiency within the Medicaid program, the District, as well as other states, adopted an auto-assignment structure in which designated beneficiaries would be enrolled into capitated *managed care organizations* ("MCOs") authorized to provide insurance services within the District. Payments to each MCO is based on its assigned population count under a negotiated rate depending upon each beneficiary's sub-classification.

During the Council's consideration of the 2006 fiscal year budget, members of the Committee expressed interest to the District's Medicaid program officials in identifying additional strategies to determine answers to the following questions:

- Is it possible to compare the amount of capitation payments made to the three participating MCOs with the dollar amount of total services paid to each of the contracted health care providers to obtain an understanding of the disparity between the two figures?
- Are the MCOs spending capitated dollars on legitimate medical services, or are payments being directed to non-Medicaid related expenses?
- Do the MCOs maintain effective internal controls within each of their relevant key business functionalities that are adequate enough to accurately report financial and encounter data results periodically to District officials?
- Do the MCOs maintain effective internal controls within each of their relevant key business functionalities to mitigate the level of financial exposure caused by fraud, abuse, and waste?

To answer these questions, the District engaged Milligan & Company to perform internal control assessments of the three Manage Care Organizations (MCOs) that are contracted

to provide medical care to the District's Medicaid population and to analyze the MCO's costs of providing care to the Medicaid population.

We have issued under separate cover a report on D.C. Chartered Health Plan, Inc.'s (Chartered) internal controls over financial reporting.

This report is intended to communicate our findings as a result of the procedures performed to analyze Chartered's costs of providing services under its Medicaid contract with the District.

Purpose and Scope:

The overall objectives of our review were to review Chartered's costs to determine the following, in comparison to Capitation payments received from the District for a specified period:

- What were the total costs of providing health care services to their Medicaid enrollees?
- Were all costs classified as healthcare costs properly classified?
- What was the nature of administrative expenses incurred to manage the Medicaid program?
- Do the costs incurred appear to be fairly valued based on the benefits received and were the costs incurred for activities that provided benefit to the Medicaid enrollees, as would be expected by the District?

Work Performed:

We selected Chartered's Fiscal Year 2005 financial data to test because 2005 represented the latest year subjected to a financial audit by Chartered's external auditors. Using audited financial data provided greater credibility to the information that we were testing. Next, we separated the Medicaid related expenses from Chartered's total expenses so that we were only focusing on Medicaid related expenses. Chartered only had two major activities, the Medicaid activity and an "Administrative Services Agreement". The Medicaid activity represented the only contract that Chartered has to provide health services. This contract represented approximately 92% of Chartered's total operating expenses. The Administrative Services Agreement represented a separate contract that Chartered had with the District, to provide administrative services only, for the District's uninsured population.

We noted that Chartered had a substantial number of financial transactions with companies that are owned by Chartered's parent company or the parent company's owner. Approximately $12 million or 13% of the expenses incurred on the Medicaid contract were spent with these affiliates. To the best of our ability, we identified all transactions with affiliates and reviewed those transactions to determine if they were conducted at "arms-length". We also sought to determine if the relationships with the

affiliates were managed in a responsible manner, consistent with what one would expect from a contractual relationship with an unrelated party.

We extracted a data file containing all encounters and claims paid for the fiscal year 2005 and tested as follows:

- We attempted to reconcile the dollar value of claims paid per the file to the amount of claims reported as expensed in the audited financial statements.
- We selected the twenty (20) largest claims paid for the year plus forty (40) additional claims selected at random for examination.
- We traced the amount of claims back to providers' contracts to determine if the amount paid was consistent with contractual terms.
- We also verified that the encounter data included with the claim was consistent with the data required by the contract that Chartered has with the District.

We also tested the internal controls that Chartered has over payments made to providers for both sub-capitation and claims. The results of those tests are reported in our report on internal controls.

We selected several administrative cost items for examination that were of questionable benefit to the Medicaid program.

Findings:

Our findings were as follows-

We found substantial related party transactions which did not appear to have been conducted at arms-length. Many of these costs appeared excessive. The exact fair value of these services provided could not always be determined within the scope of this engagement. Therefore, we took an approach that if the fair value of services actually received could not be supported we utilized the limited information that we had available to estimate the fair value. If monies were paid to a related party and no evidence was submitted to support that the services were needed and actually delivered, we assumed that these were unsupported or excess related party expenditures.

Utilizing this approach, we identified $7,679,964 of related party expenses that we felt appeared potentially excessive or were unsupported. Chartered's management indicated that the District was aware of many of the related party transactions and actually approved them. Therefore, the District should review these findings with Chartered to reach a mutual resolution. The details of these findings are presented in *Exhibit B* on page 7 of this report.

Of the administrative expenses that we reviewed, we identified $470,343 of expenses, specifically "Contribution" expenses, that did not provide obvious benefit to the Medicaid program. These findings are presented in *Exhibit C* on page 8 of this report.

Chartered's audited financial statements for 2005 showed pretax income on Medicaid activity of approximately 6.4% of Medicaid revenue. However, assuming that all of the costs identified as unsupported or potentially excessive were proven to be actually excessive, the profit would be approximately 15%.

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SECTION II: Exhibits

Exhibit Descriptions:

Exhibit A – Illustrates the total operating expenses, which include total healthcare costs and total general and administrative costs of Chartered as reported in their 2005 financial statements. The healthcare costs are presented in detail based on the type of service provided. The operating expenses are further segregated by contract.
In 2005, Chartered had two major activities, its Medicaid contract with the District and an "Administrative Services Contract." The Administrative Services contract is a separate contract with the District for which Chartered provides administrative support for the District's program to provide medical services to its uninsured population. *Exhibit A* separates Chartered's total operating costs into the two separate contracts.

Exhibit B - Illustrates related party costs totaling $12,252,207 that we identified and reviewed. The schedule also illustrates our estimate of the fair value of expenses that Chartered's management supported and the amount of unsupported related party expenses. The estimate of fair market value was based on limited information that was available and is not intended to be specific.

Exhibit C - Illustrates the Medicaid expenses per the trial balances adjusted for any unsupported related party expenses identified in *Exhibit B* and other questioned expenses noted.

Exhibit A:

Total Fiscal Year 2005 Audited Operating Expenses By Contract

	1 Total FY 2005 Audited Expenses	2 Administrative Services Contract	3 = 1 - 2 Medicaid Contract
Healthcare costs, net:			
Capitations - Primary Care	$ 11,205,134	$ -	$ 11,205,134.32
Capitations - Health Education	804,454	-	804,454
Capitations - Lab	(7,594)	-	(7,594)
Capitations - Dental	1,950,699	-	1,950,699
Capitations - Vision	398,759	-	398,759
Capitations - Mental Health	(9,935)	-	(9,935)
Capitations - Transportation	2,940,569	-	2,940,569
Capitations - Nurse Triage	332,370	-	332,370
Capitations - Home Health	(9,227)	-	(9,227)
Capitations - PCP Incentives	352,391	-	352,391
Hospital Claims - Inpatient	22,207,274	-	22,207,274
Mental Health Claims - Inpatient	1,711,487	-	1,711,487
Hospital Claims - Physician Inpatient	2,408,940	-	2,408,940
Mental Health Claims - Physician Inpatient	119,970	-	119,970
Hospital Claims - Physician ER Visit	5,854,770	-	5,854,770
Hospital Claims - Outpatient Facility	6,478,953	-	6,478,953
Hospital Claims - Outpatient Professional	1,349,800	-	1,349,800
Mental Health Claims Physician Outpatient	463,637	-	463,637
Other Medical Claims - Mental Health	18,330	-	18,330
Specialist Claims	4,271,033	-	4,271,033
Other Medical Claims - Durable Medical	896,341	-	896,341
Other Medical Claims - Home Health	383,838	-	383,838
Other Medical Claims - Pharmacy	9,434,341	-	9,434,341
Other Medical Costs	5,792,286	-	5,792,286
Ambulance Service	931,540	-	931,540
Reinsurance Expense	509,860	-	509,860
Reinsurance Recoveries	(297,177)	-	(297,177)
Coordination of Benefits - Subrogation Expense	(507,142)	-	(507,142)
Coordination of Benefits - Subrogation Recoveries	(15,961)	-	(15,961)
Provision for Incurred Claims	346,195	-	346,195
ER Triage - Hospital	10,440	-	10,440
Other	1,439,403	-	1,439,403
Total healthcare costs	$ 81,765,779	$ -	$ 81,765,779
General & Administrative costs:			
Capitations - Nurse Triage	249,020	249,020	-
General & Administrative costs	19,896,137	7,546,807	12,349,330
Other	(1,439,403)	-	(1,439,403)
Total general & administrative costs	$ 18,705,754	$ 7,795,827	$ 10,909,927
Total operating expenses	$ 100,471,533	$ 7,795,827	$ 92,675,706

Exhibit B:

Review of Fiscal Year 2005 Related Party Expenses					
	3	4	5	6 = 4 - 5	
	Medicaid	Total Related Party Expenses	Related Party Expenses @ estimated fair value	Unsupported Related Party Expenses	
Healthcare costs, net:					
Capitations - Primary Care	$ 11,205,134	$ 5,526,354	$ 2,424,039	$ 3,102,315	a
Capitations - Health Education	804,454	804,454	-	804,454	b
Capitations - Lab	(7,594)	-	-	-	
Capitations - Dental	1,950,699	-	-	-	
Capitations - Vision	398,759	-	-	-	
Capitations - Mental Health	(9,935)	-	-	-	
Capitations - Transportation	2,940,569	2,940,569	1,285,702	1,654,868	c
Capitations - Nurse Triage	332,370	-	-	-	
Capitations - Home Health	(9,227)	-	-	-	
Capitations - PCP Incentives	352,391	-	-	-	
Hospital Claims - Inpatient	22,207,274	-	-	-	
Mental Health Claims - Inpatient	1,711,487	-	-	-	
Hospital Claims - Physician Inpatient	2,408,940	-	-	-	
Mental Health Claims - Physician Inpatient	119,970	-	-	-	
Hospital Claims - Physician ER Visit	5,854,770	-	-	-	
Hospital Claims - Outpatient Facility	6,478,953	-	-	-	
Hospital Claims - Outpatient Professional	1,349,800	-	-	-	
Mental Health Claims Physician Outpatient	463,637	-	-	-	
Other Medical Claims - Mental Health	18,330	-	-	-	
Specialist Claims	4,271,033	-	-	-	
Other Medical Claims - Durable Medical	896,341	-	-	-	
Other Medical Claims - Home Health	383,838	-	-	-	
Other Medical Claims - Pharmacy	9,434,341	-	-	-	
Other Medical Costs	5,792,286	-	-	-	
Ambulance Service	931,540	-	-	-	
Reinsurance Expense	509,860	-	-	-	
Reinsurance Recoveries	(297,177)	-	-	-	
Coordination of Benefits - Subrogation Expense	(507,142)	-	-	-	
Coordination of Benefits - Subrogation Recoveries	(15,961)	-	-	-	
Provision for Incurred Claims	346,195	-	-	-	
ER Triage - Hospital	10,440	-	-	-	
Other	1,439,403	-	-	-	
Total healthcare costs	$ 81,765,779	$ 9,271,377	$ 3,709,741	$ 5,561,637	
General & Administrative costs:					
General & Administrative costs:					
Questioned G & A costs:					
Salaries & Benefits	8,445,343	127,500	45,000	82,500	i
Consulting	1,177,124	235,827	-	235,827	d
Rent	817,502	817,502	817,502	-	e
Management Fee & Consulting	1,800,000	1,800,000	-	1,800,000	f
Contributions	470,343	-	-	-	
Total questioned G & A costs	12,710,312	2,980,829	862,502	2,118,327	
Total other G & A costs	(360,982)	-	-	-	
Sub-total general & administrative costs	12,349,330	2,980,829	862,502	2,118,327	
Other	(1,439,403)	-	-	-	
Total general & administrative costs	$ 10,909,927	$ 2,980,829	$ 862,502	$ 2,118,327	
Total operating expenses	$ 92,675,706	$ 12,252,207	$ 4,572,243	$ 7,679,964	

See the legend on pages 9 & 10 for an explanation exhibits methodology and each alpha character tickmark.

Exhibit C:

Review of Fiscal Year 2005 Total Medicaid Expenses

	3	6		7		8 = 3 - 6 - 7
	Medicaid	Unsupported Related Party Expenses		Questioned Expenses		Adjusted Medicaid Expenses
Healthcare costs, net:						
Capitations - Primary Care	$ 11,205,134	$ 3,102,315	h	$ -		$ 8,102,819
Capitations - Health Education	804,454	804,454	h	-		-
Capitations - Lab	(7,594)	-		-		(7,594)
Capitations - Dental	1,950,699	-		-		1,950,699
Capitations - Vision	398,759	-		-		398,759
Capitations - Mental Health	(9,935)	-		-		(9,935)
Capitations - Transportation	2,940,569	1,654,868	h	-		1,285,702
Capitations - Nurse Triage	332,370	-		-		332,370
Capitations - Home Health	(9,227)	-		-		(9,227)
Capitations - PCP Incentives	352,391	-		-		352,391
Hospital Claims - Inpatient	22,207,274	-		-		22,207,274
Mental Health Claims - Inpatient	1,711,487	-		-		1,711,487
Hospital Claims - Physician Inpatient	2,408,940	-		-		2,408,940
Mental Health Claims - Physician Inpatient	119,970	-		-		119,970
Hospital Claims - Physician ER Visit	5,854,770	-		-		5,854,770
Hospital Claims - Outpatient Facility	6,478,953	-		-		6,478,953
Hospital Claims - Outpatient Professional	1,349,800	-		-		1,349,800
Mental Health Claims Physician Outpatient	463,637	-		-		463,637
Other Medical Claims - Mental Health	18,330	-		-		18,330
Specialist Claims	4,271,033	-		-		4,271,033
Other Medical Claims - Durable Medical	896,341	-		-		896,341
Other Medical Claims - Home Health	383,838	-		-		383,838
Other Medical Claims - Pharmacy	9,434,341	-		-		9,434,341
Other Medical Costs	5,792,286	-		-		5,792,286
Ambulance Service	931,540	-		-		931,540
Reinsurance Expense	509,860	-		-		509,860
Reinsurance Recoveries	(297,177)	-		-		(297,177)
Coordination of Benefits - Subrogation Expense	(507,142)	-		-		(507,142)
Coordination of Benefits - Subrogation Recoveries	(15,961)	-		-		(15,961)
Provision for Incurred Claims	346,195	-		-		346,195
ER Triage - Hospital	10,440	-		-		10,440
Other	1,439,403	-		-		1,439,403
Total healthcare costs	$ 81,765,779	$ 5,561,637		$ -		$ 76,204,142
General & Administrative costs:						
General & Administrative costs:						
Questioned G & A costs:						
Salaries & Benefits	8,445,343	82,500	h	-		8,362,843
Consulting	1,177,124	235,827	h	-		941,297
Rent	817,502	-		-		817,502
Management Fee & Consulting	1,800,000	1,800,000	h	-		-
Contributions	470,343	-		470,343	J	-
Total questioned G & A costs	12,710,312	2,118,327		470,343		10,121,642
Total other G & A costs	(360,982)	-		-		(360,982)
Sub-total general & administrative costs	12,349,330	2,118,327		470,343		9,760,660
Other	(1,439,403)	-		-		(1,439,403)
Total general & administrative costs	$ 10,909,927	$ 2,118,327		$ 470,343		$ 8,321,257
Total operating expenses	$ 92,675,706	$ 7,679,964		$ 470,343		$ 84,525,399

See the legend on pages 9 & 10 for an explanation exhibits methodology and each alpha character tickmark.

Legend:

Each exhibit contains numerical characters above each column containing dollar values. These numerical characters are used to illustrate the relationship of each column within and between each exhibit. For example, *Exhibit A* illustrates the numerical values in Column "**3**" will equal the value in Column "**1**" minus the Value in Column "**2**". Column "**3**" in *Exhibit B* represents amounts determined in *Exhibit A* for the same column number.

Alpha tickmarks represent the following:

a - The Chartered Health Family Center (CHFC) is a wholly owned subsidiary of DC Healthcare Systems Inc., which is the parent company of Chartered. During 2005 Chartered paid CHFC Primary Care capitation payments totaling $5,526,354. The "Unsupported Related Party Expenses" amount of approximately $3,102,315 represents the capitation rate paid to CHFC ($49.44) less the highest rate paid to other primary care centers ($21.50) multiplied by the number of enrollee months of approximately 112,746 for fiscal year 2005. We requested but did not receive documentation supporting the higher rate of $49.44 per member per month prior to the end of our fieldwork.

b - In addition to the $49.44 per member per month paid to Chartered Family Health Center (CHFC), Chartered also paid approximately $804,000 to CHFC for health education to Chartered's members. Per our conversation with the District's Actuarial Consultant, these costs are administrative should not be classified as healthcare costs.

c - RapidTrans is also a wholly owned subsidiary of DC Healthcare Systems Inc. Chartered has contracted with RapidTrans to be the sole contracted provider of transportation services for Chartered's enrollees. Chartered pays a capitation rate to RapidTrans for each of its enrollees. The capitation rate increased from $2.95 in year 2002 to $5.35 in 2005, an increase of approximately 81%. In addition, the 2005 capitation rate increase was retroactively applied to 2004, which resulted in an additional $489,981.37 of costs being charged in 2005 for services incurred in 2004.

We were informed that the highest Taxi Cab rate in the district for a one way fare is approximately $19, compared to RapidTrans average one way cost of $36.12. RapidTrans indicated the $5.35 capitation represents fair market value, based on their comparison to one other transportation company and the amount that the District pays for similar services. We question if this cost is excessive when considering the cost of alternative transportation. In addition, we question the appropriateness of the retroactive effect of the agreement reached in 2005 applicable to the entire year of 2004, which is included in the Plan's total 2005 healthcare cost.

d – Chartered has an agreement with Thompson, Cobb, Bazilio and Associates (TCBA) for consulting services not to exceed $845,000. Although fiscal year

2005 expenses did not exceed $845,000, we were unable to verify that this contract was negotiated at arms-length.

e – Chartered headquarters is owned by the DC Healthcare Systems Inc. for which Chartered remits lease payments. The lease is a triple net lease, which means all significant expenses are paid by the leasee. We did not question this cost; however, we saw no evidence that the lease was negotiated at arms length.

f - Chartered paid $1.8 million for consulting services to its parent, DC Healthcare Systems Inc. The original agreement and first amendment were valid for 3 years (May 2000 through May 2003). A second amendment was not executed until November 8, 2006, that reflects the term of the agreement to be from May 18, 2000 to May 17, 2007. Nonetheless, wire transfers were made in year 2005 without a valid executed agreement. Documents have been requested but not received to support these costs and obligation. We did receive some information that indicated that some of these costs were for services provided by the CEO of TCBA, who is also the Chairman of Chartered.

h – Amounts are carried forward from *Exhibit B*.

i – As noted in comment III – II of the Report on Examination of Effectiveness of Internal Controls Over Financial Reporting, Chartered does not have a formalized policy to fairly allocate administrative support costs to affiliates. Human Resources Department personnel disclosed that approximately 30% to 35% of their time is spent working on Chartered's affiliates. Total human resources department salaries and benefits approximated $425,000, for which 30% amounted to $127,000. Chartered's management noted that only $45,000 was recorded as expenses incurred for its affiliates for all administrative services provided. Management did not provide a basis for how the $45,000 was determined prior to the conclusion of our fieldwork. Based on our simple calculation above, which excluded payroll support related hours, there is a shortfall on the reimbursement of Chartered's administrative expense of at least $82,500. This amount does not include administrative services for payroll and general administration.

j – Chartered made several apparent charitable contributions to various organizations. One particular health center, the Whitman-Walker Clinic, received a contribution in the amount of $150,000, to support and keep that health center from closing it's business. Millco questions the benefit these contributions provide to the Medicaid program as a whole.

REPORT ON REVIEW OF OPERATING EXPENSES

OF

D. C. CHARTERED HEALTH PLAN, INC.

PERFORMED FOR

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE ADMINISTRATION

ADDENDUM

JUNE 2007

& COMPANY, LLC
Consultants and Certified Public Accountants

Meeting the Toughest Challenges.
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Table of Contents

SECTION III:

Exhibit D

Introduction:

At the request of the Government of the District of Columbia Department of Health Medical Assistance Administration, we have issued this addendum to our Report on the Review of Operating Expenses of D.C. Chartered Health Plan, Inc. issued April 2007 (the Report) to clearly illustrate the performance indicators for Chartered's fiscal year 2005. This addendum is intended to be read in conjunction with our Report.

Definitions:

According to the Centers for Medicare & Medicaid Services (CMS), one of the key means of measuring the performance of an MCO is their Medical Loss Ratio (MLR). CMS defines the MLR as the MCO's total cost for the medical services provided divided by the total revenue from monthly premiums. In addition to the medical costs, an MCO also incurs other business and administrative expenses. These costs are generally calculated as the Administrative Loss Ratio (ALR), which is general business and administrative expenses divided by the total revenue from monthly premiums. The ALRs are subtracted from gross profit to calculate operating profit. The operating margin is defined as the amount left over to pay interest, taxes, any dividends, etc. divided by the total premium revenue. (100% – MLR – ALR = Operating Margin)

According to the District's actuary employed to calculate the premium capitation range, medical expenses represent those costs that represent medical service costs, including reinsurance premiums and the offsetting entry to reinsurance recoveries. Non-medical costs, including those incurred for utilization review, quality assurance, and medical management by the MCO and the Medical Director, are to be reported under the "Administrative Expenses."

The CMS and actuary definitions noted above were used to determine the ratios calculated in *Exhibit D.*

Legend:

Column 3 and 8 are derived from page 8 of our Report.

Column 9 reports expenses reclassified for the calculation of Medical Loss Ratio or Administrative Loss Ratio in accordance with CMS guidelines and the Districts actuary instructions.

Column **10** presents the difference between columns **8** & **9**.

Alpha tickmarks represent the following:

k - Based on our discussion with management, this expense is for a nurse call service. The member would call and speak to nurses. The nurse would provide medical instruction until the person could see their physician. Also, members may call with general medical questions. It appears to be medical management which, based on the "Data Request" instructions sent to the MCO's from the District's actuary, would be considered as an administrative cost; therefore, we have reclassed these amounts to general and administrative costs.

l - We were informed that these payments were to encourage the physician to attend meetings and, more importantly, to submit encounter forms. According to the "Data Request" instructions sent to the MCO's from the District's actuary, "payments to incent providers to submit encounter forms" are administrative business expenditures; therefore, we have reclassed these amounts to general and administrative costs.

m - For audited financial statements, Chartered reclassified medical administration cost from general and administrative cost to healthcare cost. These expenses include the cost for activities such as; utilization review, medical management, medical director, etc. Based on the "Data Request" instructions sent to the MCO's from the District's actuary, these expenses should be reported as administrative expenses; therefore, we have reclassed these amounts to general and administrative costs.

Illustrations:

Figure 1 highlights the differences noted between the performance of Chartered's operations before and after our adjustments compared to industry standards. The industry results are derived from the Center for Health Care Strategies, Inc. Resource Paper: *Profiting from Proficiency: The Growing Importance of Medicaid-Focused Health Plans,* November 2003, which reported Medicaid plans on average had a MLR, ALR, and operating profit margin of 86%, 11%, and 3%, respectively.

Figure 2 highlights the combined effects of the adjustments from columns **6** and **7** in our Report on the Review of Operating Expenses of D.C. Chartered Health Plan, Inc. issued April 2007 and column **9** of this addendum on the medical expenses, general and administrative expenses, and profit before interest and income taxes.

Exhibit D:

D. C. CHARTERED HEALTH PLAN, INC.

Calculation of Significant Ratios and Average PMPM Revenues & Expenses

	3	8	9	10 = 8 - 9
	Medicaid	Adjusted Medicaid	Reclasses for MLR & ALR Purposes	Adjusted Medicaid Expenses (MLR & ALR)
Healthcare costs, net:				
Capitations - Primary Care	$ 11,205,134	$ 8,102,819	$ -	$ 8,102,819
Capitations - Health Education	804,454	-	-	-
Capitations - Lab	(7,594)	(7,594)	-	(7,594)
Capitations - Dental	1,950,699	1,950,699	-	1,950,699
Capitations - Vision	398,759	398,759	-	398,759
Capitations - Mental Health	(9,935)	(9,935)	-	(9,935)
Capitations - Transportation	2,940,569	1,285,702	-	1,285,702
Capitations - Nurse Triage	332,370	332,370	(332,370) k	-
Capitations - Home Health	(9,227)	(9,227)	-	(9,227)
Capitations - PCP Incentives	352,391	352,391	(352,391) l	-
Hospital Claims - Inpatient	22,207,274	22,207,274	-	22,207,274
Mental Health Claims - Inpatient	1,711,487	1,711,487	-	1,711,487
Hospital Claims - Physician Inpatient	2,408,940	2,408,940	-	2,408,940
Mental Health Claims - Physician Inpatient	119,970	119,970	-	119,970
Hospital Claims - Physician ER Visit	5,854,770	5,854,770	-	5,854,770
Hospital Claims - Outpatient Facility	6,478,953	6,478,953	-	6,478,953
Hospital Claims - Outpatient Professional	1,349,800	1,349,800	-	1,349,800
Mental Health Claims Physician Outpatient	463,637	463,637	-	463,637
Other Medical Claims - Mental Health	18,330	18,330	-	18,330
Specialist Claims	4,271,033	4,271,033	-	4,271,033
Other Medical Claims - Durable Medical	896,341	896,341	-	896,341
Other Medical Claims - Home Health	383,838	383,838	-	383,838
Other Medical Claims - Pharmacy	9,434,341	9,434,341	-	9,434,341
Other Medical Costs	5,792,286	5,792,286	-	5,792,286
Ambulance Service	931,540	931,540	-	931,540
Reinsurance Expense	509,860	509,860	-	509,860
Reinsurance Recoveries	(297,177)	(297,177)	-	(297,177)
Coordination of Benefits - Subrogation Expense	(507,142)	(507,142)	-	(507,142)
Coordination of Benefits - Subrogation Recoveries	(15,961)	(15,961)	-	(15,961)
Provision for Incurred Claims	346,195	346,195	-	346,195
ER Triage - Hospital	10,440	10,440	-	10,440
Other	1,439,403	1,439,403	(1,439,403) m	-
Total healthcare costs	$ 81,765,779	$ 76,204,142	$ (2,124,164)	$ 74,079,978
General & Administrative costs:				
General & administrative costs	12,349,330	10,121,642	-	10,121,642
Other	(1,439,403)	-	2,124,164	2,124,164
Total general & administrative costs	$ 10,909,927	$ 10,121,642	$ 2,124,164	$ 12,245,806
Total operating expenses	$ 92,675,706	$ 86,325,784	$ -	$ 86,325,784
Total Medicaid Revenue (Premium)	$ 99,048,249			$ 99,048,249
Operating Profit (before interest & income taxes)	$ 6,372,543			$ 12,722,465
Operating Profit Margin (before interest & income taxes)	6%			13%
Medical Loss Ratio	83%			75%
Administrative Loss Ratio	11%			12%
Total member months during MCO fiscal year	422,705			422,705
Average Medicaid Revenue PMPM	$ 234			$ 234
Average Medical Expense PMPM	$ 193			$ 175
Average G & A Expense PMPM	$ 26			$ 29
Average Medicaid Operating Expense PMPM	$ 219			$ 204

See the legend on pages 1 & 2.

Figure 1:

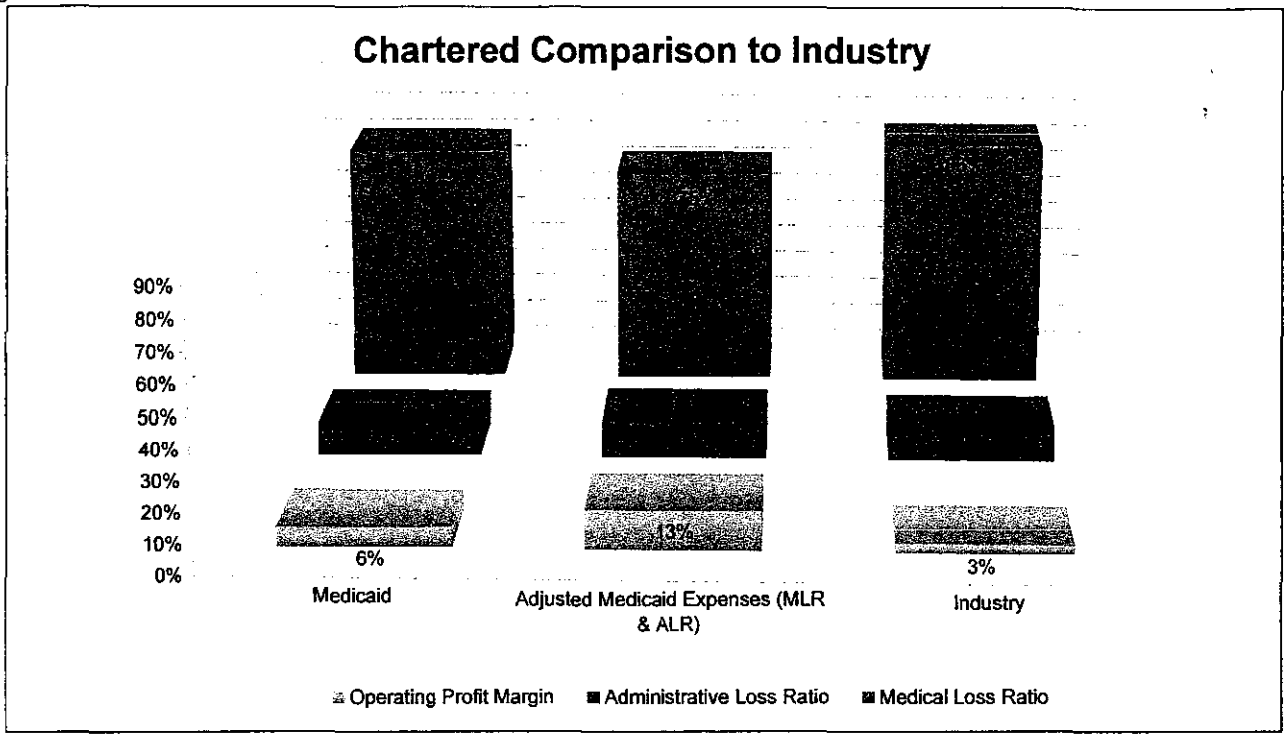
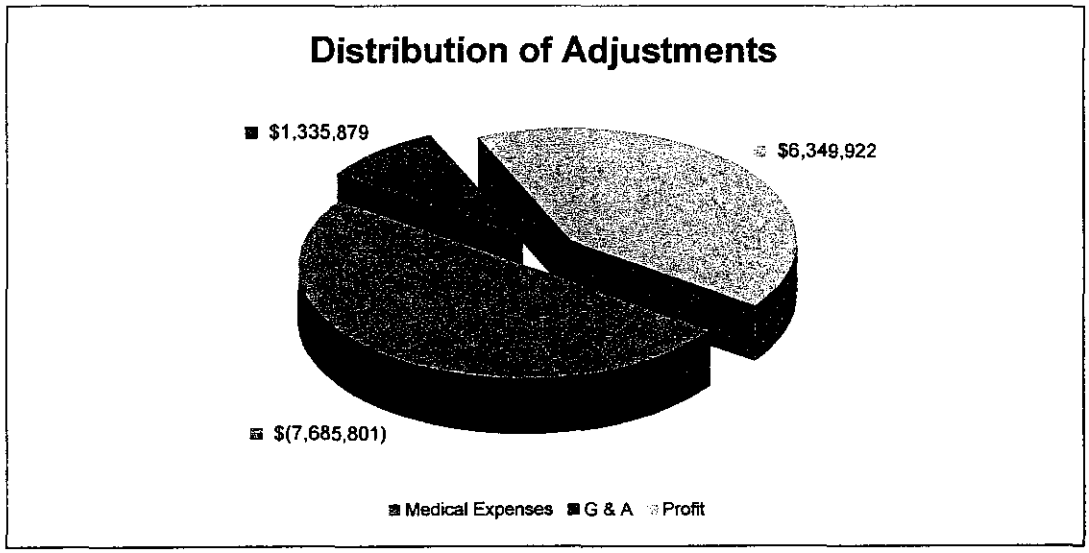


Figure 2:



DC Chartered Health Plan, Inc.
Response to Audit Findings Dated April 2, 2007

II Material Weaknesses

While Chartered Health Plan accepts the definition of a material weakness as posed by the auditors, however, it strongly objects to the suggestion that any of the items, sited herein, are, in fact, material weaknesses. Chartered maintains strongly that these findings emanate from the auditors lack of experience with managed care organizations and risk-based contracts with the District of Columbia and the Washington, DC healthcare marketplace.

In our initial meeting with Mr. Milligan at Chartered, as well as subsequent conversations, Mr. Milligan readily admitted that his company had never previously audited a Medicaid managed care organization and that he and his staff would be learning about the industry while auditing Chartered. When his staff arrived, it became readily apparent that they had little familiarity with the industry. For example, they did not know what a CPT code was. Indeed, Chartered went so far as to lend the auditors reference materials to acquaint them with the requirements of the Health Insurance Portability and Accountability Act, known as HIPAA. This lack of familiarity also manifested itself in the following: the failure of the auditor to understand how to audit claims files and what a lag report is, resulting in multiple attempts to provide them with claims information; the failure of the auditors to understand the District's process for assigning members and its impact on the reconciliation of primary care capitation payments; and the failure of the auditors to understand the difference between a primary care provider and a full service health care center that provided a wide scope of health care services, including primary care to the disadvantaged. Other more experienced auditors, such as KPMG, audit Chartered's claims files with relative ease. Chartered contends that it was this lack of familiarity that lead to the erroneous conclusions contained in the auditor's report.

Since the Enron Scandal in 2002, national accounting firms have focused increased attention on issues involving related party transactions and Board operations. Yet, in spite of this increased attention, KPMG, which has audited Chartered since 2000, did not find any material weaknesses in Chartered's internal controls, including any related party transactions or in Board operations. Furthermore, all related party transactions were conducted at fair market value and were consistently disclosed on Chartered's audit financial statements, which were provided to the Department of Health. This lack of findings of material weaknesses by an auditor with eminent experience in Medicaid in the District and nationally underscores the difference that experience makes in evaluating internal controls.

Significantly, Chartered's contract with the District is a risk-based contract. That means that the District pays Chartered to provide health care services to Medicaid eligible residents. The District, in doing so, expects that Chartered will accept the risk that the cost of providing these services may exceed the actuarially determined amount that the District pays. The District understands that to the extent that Chartered pay less for these

services than established in the capitation, Chartered has the right to retain those funds and use them for its business purposes. As a consequence, the issues raised in this audit report regarding administrative services are of no concern to the District. Chartered's administrative costs are below the actuarial determined amount and therefore are appropriate.

Finally, Chartered is a privately held company. In that regard, the individual owner must be protected against risk and liability exposure. Most of the items mentioned in the audit report would be issues for the protection of the stockholders of a publicly-traded corporation. Since the sole stockholder of the corporation was fully aware of the related party transactions at issue here, there is no lack of consistent transparency and disclosure that would lead to the alleged material weaknesses and reportable events cited by the auditor.

II-I Transactions with related parties are not supported by adequate documentation.

In this finding, the auditors assert that transactions between Chartered Health Plan and its affiliated companies lack adequate documentation. Chartered does not agree with this finding because all transactions with related parties were: conducted at prices at or below fair market value prevailing rates properly documented in agreements between the parties supported by evidence that the services were rendered and received and appropriately disclosed to the Department of Health in Chartered's audited financial statements, report, correspondence as well as disclosure during rate negotiations with the actuaries. Therefore, all contracts with Chartered and its affiliates were negotiated at arms length and in many instances the prices paid by Chartered were below prevailing market rates.

longest sentence ever

The Chartered Family Health Center

The auditors, first, challenge the primary care capitation rates paid to the Chartered Family Health Center (CFHC). While the capitation rates paid will be addressed more fully in Chartered's response to Section III-VI below, it is important here to address, the lack of understanding that permeates these findings. Significantly, the CFHC is a full service health center located on Minnesota Avenue NE that is dedicated to serving over 10,000 of Chartered's members as well as others in the community who lack the resources to obtain health care. It is not merely a primary care provider. Indeed, no other provider in Chartered's network provides the comprehensive services the CFHC provides. The center employs doctors, registered and licensed practical nurses, physician assistants, x-ray and sonogram technicians, pharmacists, receptionists, appointment and medical record clerks and management and administrative personnel. The CFHC provides primary and specialty health care to both adults and children as well as obstetrical and gynecological care, pediatric care, orthopedic care, and nutritional care. There is a fully stocked pharmacy on the premises as well as a facility for drawing medical samples for testing. CFHC also houses the WIC program, and serves as a center for training health care professionals. It also hosts health care education classes and other

community events for Chartered's members. Equally as significant, in addition to the regular schedule of clinic appointments, the CFHC offers open access, or same day appointments to enrollees, which maintains physician and health staff availability when patients present, even though they may fail to appear. These additional services provide needed access for the Medicaid population, which has a high no-show rate for appointments, and helps to prevent more expensive emergency room visits and hospital stays.

The uniqueness of the CFHC services and the role CFHC provides in a federally designated medically underserved community is the reason why the CFHC is more expensive to operate than a physician's office or even a Federally Qualified Health Center. The failure of the auditors to appreciate this operational reality of the CFHC or to even travel to CFHC and see first-hand how it operates, explains and underscores the deficiencies evident in their findings.

Because of the extensive nature of the services provided at CFHC, the capitation rate paid by Chartered is higher than the rate paid to a primary care physician and other providers that do not exclusively serve Chartered's members. The calculation on how the capitation was derived is addressed on pages 13-15 of this response.

Furthermore, in 2002 Chartered decided to cease operating the CFHC and Rapid Trans because of the significant risk and malpractice exposure from providing healthcare and risk of accidents in transporting members from high crime areas. That risk was assumed by DC Healthcare Systems, Inc., the parent of Chartered. An example of this risk is the $60 million lawsuit that Chartered has been battling since 1997 against Dr. Hayes, the former lead physician at CFHC and the premier personal injury law firm of Jack Orlander.

In 2002, Chartered as part of its decision to divert CFHC and Rapid Trans agreed to cover the cost of the $60 million litigation and that CFHC would bear the cost of settling a damage award from the massive litigation. Therefore, the liability for this lawsuit was downstreamed by Chartered to CFHC. Chartered has vigorously fought this lawsuit to defend itself and CFHC where the damage occurred.

Based on the advice of legal counsel in 2003 and the fact that the liability insurance carriers for malpractice coverage were in bankruptcy, Chartered began to fund a reserve for self insurance for CFHC to cover the risk and exposure from this lawsuit and to build this into the rates paid to CFHC. The current estimate to settle this lawsuit ranges from the $4.5 million demanded by the plaintiff or up to $7.5 million if the case goes to trial by a DC jury.

This pending lawsuit was disclosed to the auditor in our memo on the rate calculation for CFHC, but he did not follow-up with management to ascertain any of the details.

Therefore, Chartered does not agree with the auditor's findings that amounts paid to CFHC appear to exceed amounts paid to unrelated parties for similar services, because

the auditor failed to consider the scope of services provide by CFHC, exclusively to Chartered members, the analysis performed by Chartered in developing the rate, the record of services rendered at CFHC, the comparative data with similar health centers, and the massive liability exposure faced by CFHC from the Hayes case.

The auditor also questioned the $1.8 million paid to DC Healthcare Systems, Inc. (DCHSI), Chartered's parent company. This $1.8 million was reimbursement paid to DCHSI for consulting services rendered and reimbursement for administrative expenses incurred by DCHSI for Chartered and the debt service on the $3.5 million loan for the acquisition of Chartered in May 2000. Therefore, the auditor's statement that the $1.8 million was totally for consulting services is erroneous. The consulting services rendered by DCHSI Chairman and its general counsel were billed at or below prevailing fair market rates and valuable services were rendered by both individuals to further Chartered's business objectives in accordance with the terms of the agreement with DCHSI and Chartered, were in fact paid in accordance with the terms of the contract and the services rendered are adequately documented and supported by the result generated for Chartered and the value received.

The auditor's comments about transportation services, rent, and other consulting and professional services are misleading because all of the services were performed in accordance with the respective agreements and were paid by Chartered at or below prevailing fair market rates in al cases as further addressed below. Significantly, it should be noted that Chartered does not have a cost-plus contract with the Department of Health where administrative expenses are part of the cost calculation. It has a risk-based contract. Under these circumstances, administrative expenses are a multiple of medical expenses and calculated at 15%. Because Chartered's administrative expense is less than 15%, the administrative expenses as a whole are clearly not excessive.

The auditors go on to find that the transactions between Chartered and its affiliated companies are not arms-length transactions, however, the auditor fails to provide either a definition of what constitutes an arms-length transaction or to indicate how the transactions might have differed if an arms-length transaction had, in their definition, taken place. There are two important components to an arms-length transaction, both of which are clearly met by Chartered. The first element is disclosure which has consistently been adhered to by Chartered in audit reports to MAA, consequently, the Medicaid agency is very aware that the entities are affiliated. The second element is that the rate charged to Chartered is at or below fair market value as demonstrated by the fact that the related party's rates are at or below charges for such services in the open market. Again, Chartered consistently has provided evidence that its related rates are at fair market value.

Transportation Costs

The first area challenged here are transportation costs. Apparently, the auditors challenge the amount that Chartered paid to RapidTrans for transporting its members. As indicated above, the District government is well aware that Chartered and RapidTrans are affiliated and know the rates that Chartered pays to RapidTrans to transport its members. To determine rates for RapidTrans, Chartered assembled comparative market data for non-emergent Medicaid transportation. As part of that analysis, Chartered compared the District, Maryland, Virginia, Delaware and US rates for non-emergent Medicaid transportation for the year 2001, the most recent data available. That analysis revealed that the RapidTrans rates are at or below rates from unrelated entities for similar services. A chart displaying the transportation data was provided to the auditors. The information provided also showed that in Fiscal Year 2005, the RapidTrans rate was almost ½ the non-emergent transportation expense for the Medicaid population in the District on a PMPM basis.

However, there are customer service related issues here that because of the auditors' unfamiliarity with the District, they fail to fully grasp. Our members are challenged to respond promptly to pick-up times. RapidTrans is then in a posture of either leaving a member to miss an appointment or make other members late or miss their appointments altogether while they wait for a tardy member to appear. If the member misses a medical appointment, it may mean weeks or months to reschedule. RapidTrans is set up to respond to this with additional vehicles or other re-routing so that members can meet appointments and have access to care. Also, as indicated above, many of our members have large families and often appear with six (6) or more children without prior notice. Other transportation vendors that were considered to provide transportation services advised Chartered that they could not accommodate large families and that they could only transport two family members per trip. It should be noted that 33% or 10,689 of Chartered's members were from a family size of 2 or more. RapidTrans' ability to handle large families at no cost is critical to Chartered's ability to meet its members' health care needs.

The detail analysis and price comparison with other vendors of prices and scope of services and limitations including the risk of unreasonable price escalations clearly documents that the transportation expense meets the fair market value test. Chartered has learned that the auditors believe that the Medicaid members transported by the District were sicker than Chartered members were, but they offer no proof that is the case. One has to question, why they accept this assertion with no documentary support, but challenge Chartered's documentation when it includes the annual report of a District agency.

The Payments to the Holding Company

The second issue here is the rent that Chartered pays to the holding company. In 2005, Chartered paid DCHSI $25 per square foot for its office space pursuant to a triple net lease. Similar to the transportation example, Chartered meets the arm's length

transaction test. For example, the rent paid is comparable to rents in the area market. In fact, at its old location, 820 First Street, NE, Chartered was paying $25.90 per square foot for basement level space for some of its space and $27.68 and $33.29 per square foot additional space that it acquired to meet is operation needs, also a triple net lease. Chartered also compared the rent charged by DCHSI to other rents in the area. Comparable rate and proposals received by Chartered from other landlords were as follows:

- 1400 K Street NW $38.50 per square foot;
- 1129-20th Street NW $35.00 per square foot;
- 1155 15th Street NW $38.50 per square foot; and
- 501 Third Street NW $38.00 per square foot.

Chartered information in this regard was available, but the auditors never asked for it, and again the auditors drew their conclusions without critical information, leading to their erroneous material weakness finding. This finding is just not accurate.

The auditors also question the consulting and professional fees charged to Chartered by the affiliated entities. While they are not explicit in their allegations, we must assume that they are referring to the fees charge by the DCHSI and by Thompson, Cobb, Bazilio & Associates for management consulting services. Once again, we are constrained to point out that these are administrative costs and not germane to the medical costs issues that should have underlain this audit. The rates charged by DCHSI to Chartered includes the management and consulting fees for two individuals, the Chairman and legal counsel who assumed other duties and also the fees charged by other independent vendors for work done for Chartered.

The Chairman's time was charged at $198 per hour and counsel's time $205 per hour. As noted above, fair market values are that which are at or below charges for such services in the open market. The Chairman's time is below what he charges in his work as a Partner at Thompson, Cobb, Bazilio & Associates, PC (TCBA), an accounting firm. Mr. Thompson's General Services Administration rate is $231.86 per hour. On the GSA Schedule, on which the Chairman's firm is listed, accounting firm partner rates are from $172 to $296 per hour. The Chairman's rate for non-government work is $225 per hour. KPMG, Chartered's external auditors' standard billing rates for a partner is $700 per hour, a senior manager is $600 per hour, and a senior accountant is $375 per hour. Counsel's time was billed at $205 per hour. At his previous firm, counsel's time was billed at $325 per hour in 2002. Furthermore, at present, Chartered pays law firms, such as Epstein, Becker & Green between $360 and $400 per hour for attorneys with the same experience as its counsel and Feldesman Tucker between $250 and $315 hours for attorneys with less experience.

Chartered also regularly pays other independent consulting firms between $110 and $360 per hour for other consulting services. It is clear from the foregoing that Chartered obtained more than fair market value for the services rendered by the DCHSI personnel at issue here.

The auditors also claim that no evidence was present to support that services were actually performed. However, the auditor never examined evidence of work products when it was provided to them concerning the valuable work performed by TCBA and by DCHSI, which is adequately documented and explained in information provided to the auditor. It follows, then, that their claim that no documentation to support these fees was presented is without merit. If it mattered to them, they should have requested it.

In sum, the auditors' claim that Chartered's transactions with its affiliates were undocumented and does not provide fair value is clearly erroneous. Chartered does document it transactions. The relationships between the parties are well disclosed to the District government and the rates charged were well within what is charged in the marketplace for similar services.

With respect to the auditors' recommendation, Chartered respectfully disagrees. All related party transactions meet the fair market value test and were adequately disclosed. Moreover, the auditor has not provided a test for fair market value to show that Chartered's analysis of open market prices in invalid. The review of transactions between affiliated companies is designed to ensure that investors and third parties are fully aware of what happens and conduct their affairs accordingly. With respect to the transactions here, all of the interested parties were aware of the transactions and the investor approved them. There was full disclosure and approval. Moreover, Chartered is audited by KPMG each year and supplies that audit to MAA. All of the reportable transactions are in that audit. This audit and the fair market value comparison is all that should be required for an organization of this type. Furthermore, Chartered's rates are negotiated and approved by MAA's actuaries and Chartered actuaries. This recommendation again demonstrates a fundamental lack of understanding of the industry and the nature of this contract.

II-II CHARTERED'S control environment and risk assessment process need to be improved.

Chartered is at a loss to understand the nature of this finding. Chartered does have internal controls and maintains an internal control environment. With respect to the recommendations, Chartered would point out initially that again, Chartered is a privately held company and much of the discussion related to public held companies or not-for profit entities. Also, as indicated above, Chartered's activities are audited each year by KPMG and they have not noted the deficiencies that the auditors here have indicated, and unlike these auditors, KPMG has considerable experience auditing managed care organizations.

However, with regard to the requirements for control environment, Chartered already has these elements. Chartered has a Board of Directors that is comprised of individuals who are not employees and who have extensive health care and business experience. Chartered also has an Internal Auditor. Chartered also has a Code of Conduct that every employee signs when hired and is reinforced in the new hire orientation as well as regular staff meetings. In addition, selected staff, including all claims staff, receives additional

Fraud, Waste, and Abuse training provided by Ingenix to enhance their ability to detect this type of conduct when it occurs.

Also in the report, the auditors suggest the Chartered obtain a "whistleblowers hotline." However, Chartered has an established Compliance Hotline maintained by National Hotline Services, Inc. The number, 1-800-688-2594, is given to employees when they are hired, appears on Chartered's internal and external websites, and is in our member and provider handbooks. The reports from the hotline go to both the Compliance Officer and the Internal Auditor and the reports are kept in a log.

Chartered also has an established ethics policy for all employees including senior management.

Chartered admits that it does not have a separate audit committee, but no current employees of Chartered sit on the Board and therefore, the reports of the external auditors are in no way hindered. Also, both the Compliance Officer and Internal Auditor have the capacity to speak directly to the Board regarding any control issue. However, Chartered will investigate the merits of an audit committee. The other recommendations are totally without foundation or merit.

II – III CHARTERED was unable to demonstrate that it has adequate controls over IT Functions

In November 2006, Samlin Consulting Services (Samlin), a sub-contractor to Milligan and Company started the internal control and Information Technology (IT) fieldwork at Chartered. Chartered personnel were assured at the kick-off meeting that the auditors would finish their fieldwork in 2 –3 weeks. Chartered made all parties aware that between January 1 and May 1, it had a number of significant activities to perform, many required by contract and law while others were imposed by MAA and would have limited ability to respond to the auditors' requests.

Nonetheless, Chartered's IT staff spent a significant amount of time with the auditors walking them through the managed care main frame systems, the processes and the functionality of IT operations, including security. After four (4) weeks of intensive fieldwork, Samlin introduced the CMS Information System Capabilities Assessment for Managed Care organizations questionnaire and expected Chartered to complete it. The questionnaire contains over 45 pages of questions that were redundant to information already provided to Samlin. As our expectation was that the field work should have been completed, and Chartered's IT staff was supposed to move on to their other critical tasks, Chartered discussed the reason for not receiving the questionnaire at the beginning of the fieldwork rather at what Chartered concluded was the end of the process. This would have saved time; however, Mr. Samlin stated that they just got the CMS questionnaire, and it was not available to them at the beginning of the fieldwork. Chartered discussed the possibility of Samlin completing the questionnaire with the extensive information that they gathered in the past weeks of fieldwork. This would have afforded Chartered's IT staff the opportunity to move on to focus on HEDIS Measures for 2006, continue with

NCQA accreditation preparation and the year-end closing processes. Samlin refused this request, and in February of 2007, Mr. Samlin called and requested the completed questionnaire. Although, he was told that the questionnaire was not complete, Chartered advised him that the missing areas were covered in the information that had been provided during their fieldwork. Mr. Samlin asked that the questionnaire be sent to him and that he will let Chartered know if he required any additional information. Chartered submitted the questionnaires to the Samlin on February 22, 2007. Chartered heard nothing further from Mr. Samlin.

Despite all the urgent matters and the important deadlines that Chartered was facing with MAA, and NCQA, Chartered spared no efforts to accommodate, educate and guide the audit team to understand Chartered's custom tailored Medicaid managed care system. However, the statement in Section II –III of the audit report *"Chartered's inability and unwillingness to provide this data or equivalent data represents an inability to demonstrate adequate internal controls over its IT systems"* is unfounded and untrue. Chartered provided the equivalent data before the questionnaire was even presented. The problem rested in the lack of preparedness of the auditors to conduct the audit, not in Chartered's unwillingness to provide information.

In addition, please find attached Chartered response to the deficiencies noted on Appendix A by Control Objective.

KPMG, Chartered's auditors audits our IT controls and have made recommendations that were implemented by management. But the findings detailed in this report are unsupported and inconclusive in many respects. Chartered will review them and where warranted will implement corrective measures.

SECTION III: Reportable Conditions

III-I No SAS 70 report is obtained from service centers responsible for processing claims and encounter data

SAS 70 audit reports on the internal controls of service centers that process data for Chartered may be helpful to Chartered's auditors in the evaluation of the overall system of internal controls. However, our external auditors, KPMG, and other auditing firms have reviewed and evaluated our internal controls and did not request such reports. Although we feel that there are substantial controls over the data processed by service centers, we will ask them to provide SAS 70 reports, which we will make available to our auditors

III-II CHARTERED does not have a formalized policy to fairly allocate administrative costs to affiliates.

This finding is not accurate. As we demonstrated to the auditors, Chartered has a reasonable and established method of allocating any cost for services rendered by Chartered to its affiliates. The following is the brief description of the methodology that

Chartered uses to bill for the administrative support services in handling of the payroll, employees benefits, accounting and other related administrative services:

> "Chartered shall estimate a percentage of each of its employee's time spent/incurred to provide the administrative services to affiliates and, based on that estimate, charge affiliates for a correspondent percentage of the employee's base salary, plus 30% for estimated payroll taxes, fringe benefits and overhead costs, plus 10% margin fee."

This process was documented and covered in a Memorandum of Understanding (MOU) dated January 23, 2003.

Based on the above, in 2005, Chartered billed RapidTrans $45,169.48 (Based on the auditors' request on March 30, 2007, a copy of this bill was provided to auditors on April 2, 2007). Also, in 2005 Chartered billed Chartered Family Health Center $73,335 for administrative and accounting functions, in accordance with Chartered's formal methodology for allocating costs to affiliates.

III-III Prepare and document formal procedures to minimize fraud and inaccurate claims and encounter reporting by providers

Chartered Health Plan has a Compliance Plan that addresses fraud, waste, and abuse. The essential elements of a Compliance Program include the following:

- A Compliance Committee that meets regularly to provide compliance oversight- Chartered has such a committee;
- A Compliance Officer who is a member of senior management- Chartered has such an officer who has direct access to the Board of Directors;
- A Compliance Plan- Chartered has a compliance plan
- A Code of Conduct that includes a statement that employee will not be sanctioned for reporting Fraud, Waste, and Abuse – Chartered has such a plan and has employees sign that they have received it.
- Employee Training- Chartered has a new employee orientation where the provision of the Code of Conduct, as well as what constitutes Fraud, Waste, and Abuse are discussed. There is also additional focused training on Fraud detection and HIPAA provided as well as recent courses in coding;
- Policies and Procedures which require employees to immediately report suspected instances of fraud- Chartered has such policies;
- Background checks on employees– Chartered conducts an initial background check when an employee is hired and Chartered now conducts an annual check of criminal and OPM disbarment records to ensure that no employee has been bared from federal programs or convicted of a crime that would effect employment;
- Policies that require medical providers to disclose adverse actions against them by public entities or accrediting bodies- This is in Chartered provider contracts and Chartered check the status of providers with these entities on a regular basis;

- Performance evaluations – Chartered has a performance evaluation process for employees, including senior management;
- Risk Assessment- The Compliance Committee, the Quality Management Committee, and the Board regularly review risk areas;
- Annual approval of the Compliance plan – The Board has commenced approving the Compliance Plan effective this year.

In addition, as Chartered demonstrated to the auditors, it has extensive protocols in addition to the Ingenix product that it uses to detect any claims waste, fraud and abuse. All Chartered's claims are adjudicated with 3 levels of audit; 1) "Auto Audit" software to detect any outpatient bundling and unbundling of services by CPT code based on the AMA rules of coding and billing for services; 2) "Charge Master" audit of all inpatient claims to determine that all billable services are appropriate and in accordance with CMS allowable billable services and 3) Manual Claims Audit by internal claims auditors. In addition, Chartered has contract with IHAS to perform on-site hospital audits of certain inpatient charts.

In 2005, as a result of these claims audit protocols, Chartered recovered $3.79 million that reduced the total claims cost and healthcare costs.

One of the auditors' concerns is that they believe a major portion of Chartered's health services are provided through an affiliate. This is not true. Chartered pays less than 12% of its total medical cost to RapidTrans and Chartered Family Health Center, and the majority of these payments are in monthly capitation which down streams the total risk to these entities.

Also, Chartered is aware that there are two major concerns with managed care fraud. The first is underutilization and the second is prescription drug fraud and abuse. Based upon credentialing reviews in 2005, Chartered commenced programs to address both issues in 2006. Chartered now reviews narcotics utilization on a monthly basis to identify potential instance of fraud and abuse by members, providers, and/or pharmacies. Chartered has reported potential fraud cases to MAA and addressed the issues of abuse with such success that only two individuals out of more than 20 still have serious issues today. Second, with regard to underutilization, based on 2005 data, Chartered commenced a program to identify members who had not seen a physician in the preceding 12 months and made outreach effort to have that member access care or to address any barriers that the member might face. This effort resulted in a 2007 reorganization of Chartered to focus more of preventive efforts. All of this emanated from Chartered Compliance program which cannot be considered inadequate.

Finally, Chartered is reviewing the services provided by Ingenix and other potential vendors to determine whether there is a more cost-effective fraud detection program available. This is a clear indication that Chartered's program is vibrant and aggressive in its nature and has resulted in significant cost savings and recovery.

III – IV Prepare and document formal procedures for extraction and consistent reporting of claims payments and encounter data

We disagree entirely with this finding. The auditors did not include all the facts surrounding their audit of this area in their report. Their objective was to reconcile the detailed claims cost to the amount recorded on the General Ledger and determine the number of encounters in 2005. The standard practice used by experienced actuaries and auditors would be to reconcile the lag report's paid claims data to total annual claims recorded on the general ledger. Then claims cells from the lag report would be reconciled to the detailed claims paid file. Since the auditors were unfamiliar with the nuances of claims processing and lag reports, we made considerable efforts to assist them in grasping the related concepts. However, they did not accept our advice and took another approach.

The following represents a true chronological account of the requests from the auditors and our responses:

- The disk noted in the finding as the first file is not, indeed, the first file on CD that was provided to the auditors. The initial request for claims data was made on February 14, 2005. The auditor requested claims data for all dates of service (DOS) in calendar year 2005. The first CD of Claims we provided to the auditors was extracted by Information Systems (IS) and reviewed by the auditors. IS and Finance were informed that the data did not match the claims lag reports for the year. Finance explained to the auditors that the lag report is on a "paid basis" and the data they requested was based on DOS.

- They requested a 2nd CD consisting of all claims in calendar year 2005 based on paid dates, including all lines, e.g., procedures, etc. The second CD was created with this data, as requested, and provided to the auditors. The auditors complained that the CD included incorrect field separators, while in fact, these were "Time Stamps." The auditors asked us to explain this file and the field separators, which they believed to be incorrect data. We determined that the file was correct and that the auditors did not want the date stamp data associated with each line. This was corrected and a third CD was presented to the auditors on March 1, 2007.

- After further discussion with the auditors to assist them in analyzing the data, IS determined that the auditors would need additional information (claims reversals) that was not mentioned in their original request. A fourth CD of paid claims lines with reversal data was created and delivered on March 7, 2007. This, however, was once again deemed insufficient by the auditor.

- Another conversation between IS staff and the auditors ensued, after which, it was decided that zero-dollar claims should be included to ensure that the auditors could determine accurate encounter data. This was not a part of their original request, again demonstrating their lack of understanding of their objectives and

the claims payment process. A final (fifth) CD was created covering all claims, including zero-dollar claims. This CD was delivered on March 22, 2007, with the full understanding that it would require more effort on the part of the auditors to drill down to a sample based on individual claims.

- At this point, the auditors questioned why the number of claims increased from approximately 770,000 to approximately 880,000. We explained that each row in the file does not represent a claim, and that both files contained the same data, only in a different display format. To demonstrate this, we produced a report from the file showing 321,300 unique claims paid for the calendar year 2005.

The apparent reason for the creation of so many CDs was the inexperience of the auditors in auditing claims data in a managed care environment. If they had explained to us what they wanted to audit, we would have extracted the pertinent data elements needed to be included in the file, in which case, only one CD would have been needed. In fact, the auditors admit in their report that there was no material difference in the financial and non-financial data between the files produced.

According to the auditor's finding on page 10: "*Millco performed a comparative analysis on the files received and noted that the results of financial and non-financial data did not change by a material amount*". Then, the report on page 10 contradicts the above statement by alleging an inconsistency in extraction of the claims and encounter data files, while, in fact, the inconsistency was created as a result of the multiple data requests by the auditors.

Concerning the auditor's recommendation, we have formal procedures for extracting data from the claims system for internal and external reporting purposes. However, the information requested by the auditors would be classified as ad hoc, at best. While we have standards for ad hoc reporting, the accuracy of the reports depends on the clarity and completeness of the request. The auditors did not understand what information they needed from the claims system to satisfy their audit purposes, as evidenced by the omission of critical data elements from their numerous requests.

III-V Controls should be strengthened over payments to pharmacies

As described to the auditors, payments are made via wire transfer to the pharmacy benefits manager, Caremark, on a bi-weekly basis, based upon a request faxed to us from Caremark. The biweekly payments are not individually reconciled, however; on a monthly basis, Caremark submits an electronic report of claims made by date of service and a monthly claims lag report showing the paid pharmacy claims by date incurred. The Director of Finance reviews and analyzes the payments to Caremark and reconciles the payments and the detailed electronic claims report received to the lag report and any differences are reviewed and adjusted on subsequent reports. Therefore, we do not agree with this finding, but will enhance these procedures where warranted.

III – VI Certain costs are paid for and paid to Chartered Family Health Center that are charged to healthcare costs without supporting documentation.

Chartered is at a loss to determine what the auditors mean that "certain costs" are paid to CFHC without adequate documentation. One should note that, it is clear that the costs are documented because they actually saw them. What it appears that the auditors are trying to say is that Chartered cannot justify its capitation payments to the CFHC. Chartered provided a detailed explanation as to how it reached its full risk capitation payment to the CFHC. The auditors simply rejected the explanation without exploring any of the financial or operational components of the analysis. Instead, they simply compare the costs of the Health Center to those of a primary care practitioner and state that the $49.44 per member per month is unsupported when compared to the $21.50 paid to providers. The problem here as with other areas of the "Findings" is that the auditors never bothered to acquaint themselves with what the CFHC does by at least visiting the health center to see that it is nothing like an ordinary doctor's office. They never attempted to gain an understanding of the challenges facing a Medicaid population or what a provider has to do to meet those challenges.

The capitation rate for the CFHC in 2005 was computed based upon the following chart:

SERVICE CATEGORY		PMPM
Primary Health Care	$	20.00
Member Education Classes – Total of Six Classes	$	4.86
Fetal Alcohol Study	$	2.92
Membership Outreach	$	2.92
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	$	2.80
Laboratory Testing	$	1.94
Pre-Natal Education	$	1.94
Space and Overhead for Mental Health Program	$	1.94
HEDIS Encounters for All Members	$	1.80
WIC Program	$	0.97
Transportation Hub - Rapid Trans and Wellness Van	$	0.97
Urgent Care Administrative Services	$	0.97
Primary Care Practitioners/Behavioral Health Providers/Medical Specialists	$	0.90
Pharmacy Services	$	0.90
Disease/Case Management Services	$	0.90
Substance Abuse Services	$	0.45
Diagnostic Testing (i.e. radiology)	$	0.45
Pregnancy Related services (prenatal, perinatal and postpartum care)	$	0.45
Diabetes Care Services	$	0.45
Behavioral Health and Social Service Counseling Services	$	0.45
Vision Services	$	0.45
TOTAL	**$**	**49.44**

In pricing the capitation for the Center, Chartered must quantify the cost associated with each of the ten items listed and/or look for comparable pricing structures for clinics and other health centers that provide like services. Below is a scheduled with comparable pricing structures for Washington, DC and other metropolitan areas on in the country which shows that the CFHC's capitation rate is comparable to market rates. Please note that these price ranges are all for health centers that provide comprehensive health services to the medically underserved.

Health Center Reimbursement								
	Region	**Effective Date**	**Cost Per Visit**	**Range of PMPM Capitation Based on Cost/Visit with 3.5 to 4.5 Visits Per Member Per Year**				
1	Washington, DC Primary Care Avg.	1/28/2006	$ 135.00	$	39.38	to	$	50.63
2	Austin, TX FQHC Avg.	12/1/2005	$ 163.35	$	47.64	to	$	61.26
3	Miami-Dade, FL FQHC Avg.	10/1/2006	$ 136.19	$	39.72	to	$	51.07
4	El Paso, TX FQHC Avg.	12/1/2005	$ 136.12	$	39.70	to	$	51.05
5	Michigan FQHC Avg.	1/1/2006	$ 130.37	$	38.02	to	$	48.89
6	Central FL (Orlando Area) FQHC Avg.	10/1/2006	$ 123.87	$	36.13	to	$	46.45
7	Dallas, TX FQHC Avg.	12/1/2005	$ 114.74	$	33.47	to	$	43.03
8	CMS Upper Payment Limit Avg.	1/1/2006	$ 112.96	$	32.95	to	$	42.36
	Average			**$**	**38.38**	**to**	**$**	**49.34**

Furthermore, it should be understood that the Health Center is located in an area that is underserved by health care providers. It seeks to serve a population that faces a number of challenges in addition to their health disparities. It is important to maintain access for this population, which finds it very difficult to make and to keep appointments. Consequently, to ensure capacity is available when members seek to access care is critical to providing health care to our members. In addition, the Health Center has rather high medical malpractice insurance premiums that must be paid.

It should also be noted, the Health Center and Chartered Health Plan are involved in a major malpractice lawsuit with a former physician-employee of the Health Center. The legal action seeks $60 Million Dollars in damages. This case involves the delivery of a baby at the defunct Columbia Hospital for Women that settled the Hospital's liability. The Health Center will bear the cost of the settlement of the malpractice case because the insurance company that would have paid for much of the litigation is now bankrupt. However, given the fact that Chartered Health Plan and the Health Center are the only viable entities remaining in this matter, the plaintiff and the attorney of the child are pursing this matter vigorously. These are factors why Chartered ceased its ownership of CFHC in 2002 and sold it to DCHSI with all its risks and exposure. At some point, this matter may well result in a large settlement just to avoid more legal expense, and as noted above, the Health Center will fund this settlement. It is also Chartered Health Plan's recognition of costly factors of this nature that go into the determination of the CFHC's full risk capitation payment from Chartered.

The central question here as before is whether the Medicaid program received fair value for these services. As noted above, the elements of fair value are (1) that the agency knew of the relationship and (2) that the rate charged to Chartered is at or below fair market value as demonstrated by the fact that the related party's rates are at or below charges for such services in the open market. Also, these rates were disclosed in Chartered's cost reports to MAA actuaries and was also disclosed in Chartered's annual audited financial statements provided to MAA. Therefore, Chartered does not agree with the auditors' finding.

III-VII The number of enrollees in sub-capitation arrangements with PCP differ from the number of enrollees in sub-capitation arrangements with other

The auditors were provided the capitation reports, as requested, and because of their inexperience with the capitation process, we spent a substantial amount of time explaining the reports to them. Also, our Manager of Membership and Eligibility Verification spent a substantial amount of time reviewing and explaining the reports and the eligibility process with the auditors. Chartered staff also spent a significant amount of time explaining capitation and the managed care retro-eligibility processes to the auditors.

In fact, the monthly membership number (as calculated on the last day of the month) and the total membership used for capitation payments are never the same in any Medicaid managed care setting. The reason for the difference is that, in the Medicaid program, the District makes member additions and deletions retroactively for 90 days. As a consequence, the number used for monthly capitation payments can be above or below total membership calculated on the last day of the month. In addition, the file containing the monthly membership number is typically received on or about the 26th of the month. However, Chartered receives daily enrollments and disenrollments from the District. As a result, the monthly membership number changes daily and subsequent capitation payments are adjusted to reflect these retroactive enrollments and disenrollments.

Therefore, because of these factors, Chartered does not agree with this finding, but will review these processes and enhance the controls where warranted.

Payroll and Human Resources

III – VIII Improve controls over payroll and Human Resources Departments.

The first bullet point maintains that Chartered has no system in place to verify the accuracy of information place into the human resources system on a regular basis. This is not correct. The information is reviewed a second time by the Payroll accountant who has to perform several calculations and verifies that pay rates and deductions are correct. In addition, the employee receives a pay stub that indicates his/her information. Also, on

an annual basis, KPMG tests Chartered's payroll to make sure that there are no phantom employees and that pay rates are correct and documented.

The second bullet indicates that Chartered has no policy and procedural manual that address how human resources tasks are to be performed. There is a manual that lays out Chartered's expectations as well as rights and responsibilities. It does not delineate the precise steps that have to be taken, but does lay out the general parameters of what happens to employees when they are hired. There are written job descriptions that outline what employees are expected to do and this explains human resources responsibilities; therefore, employees are fully aware of what they have to do. In addition, the forms used by Chartered to recruit and hire are all assembled and the personnel loading process merely requires that the information on these forms be loaded into the ADP H/R system.

The assertions in the third bullet represent what Chartered would contend is a rush to judgment by the auditor. The auditor was told in an interview that human resources personnel do not have access to the ADP payroll module and that the payroll accountant does not have access to HR Perspectives (the ADP HR module). In testing this control, the auditor asked Makeba Washington in Human Resources to attempt to log onto the ADP payroll through the HR Perspectives module. Ms. Washington logged on to HR Perspectives. The auditor asked her to press an icon that she was unfamiliar with and found that it when to ADP-Payroll. The auditor assumed from this that this employee had access. This was not the case. Human Resources personnel cannot log on to ADP's payroll module from HR Perspectives and this can be easily verified. The auditors have been advised of this; nonetheless, they persist in this erroneous interpretation of the facts.

With respect to the fourth bullet point, while it is true that the payroll accountant submits data to ADP, our payroll processor, and also receives the checks from ADP, there are significant mitigating controls to ensure that the payroll is accurate and secure.

The payroll accountant cannot create payees in the payroll system. As indicated above this can only be done only through ADP's HR Perspectives module managed by the human resources personnel. The payroll accountant does not have access to the HR Perspectives module and the human resources personnel do not have access to ADP Payroll module. No payroll can be established in the ADP Payroll module by a department head. We use Personnel Actions Request (PAR) forms initiated by the hiring department head and approved by an executive level officer, the Chief Financial Officer, or other management person, as required. The Human Resources Department sets up the new employee in the HR Perspectives, which interfaces with the ADP Payroll module, and the payroll accountant enters the withholding information (e.g., W-4 information). In addition, all new employees are required to attend new employees orientation sessions held once monthly. If a new he or she cannot attend, they are contacted. If they cannot be contacted, the appropriate investigation takes place.

As a further control, all time sheets (prepared by exempt employees and certain non-exempt employees) and punch edits (for time clocks) are reviewed and approved by

department managers prior to submission to payroll. Payroll registers are reviewed by either the Director of Finance or the CFO upon receipt from ADP and the dollar amount of the payroll is compared to the previous pay periods. Any unusual discrepancy is investigated and resolved. The payroll accountant does not distribute the checks to the employees, but rather to the department managers.

All employee changes, including new hires, raises, bonuses, terminations, etc., are documented on a Personnel Action Request (PR) form signed by various persons, including the department head, the CFO, and other management, as required.

In response to the fifth bullet, Chartered, CFO or the Director of Finance, as stated above, reviews the payroll registers and investigates any unusual fluctuations in pay from prior periods. Supervisors receive budget reports showing their payroll costs compared to budget on a monthly basis. They are required to notify management of any unexpected variations.

In response to the sixth bullet, Management approves all wire transfers prior to submitting the request to the Chairman, who has wire transfer authority. This is not a weakness. It is, in fact, an added control over the safeguarding of cash assets. The signed wire transfer form is maintained by the Chairman's office; however, all wire transfers made are verified and tracked by the Finance Department in their normal cash control processes, including bank reconciliation.

III-IX Improve documentation and support over cash disbursements

- As explained to the auditors, these transactions were consulting and other expenses that were charged by journal entry, then adjusted and allocated back to the parent company. Chartered did not pay these expenses and they are not included in Chartered's financial statements.

- The auditors did not ask us for 31 journal entry batch listings. Our records show that they asked for 55 items, including the following:

  - 45 AP invoices
  - 10 GL journal entries

  Chartered provided all applicable invoices and entries to the auditors.

- As Chartered personnel explained to the auditors, approvals of check requests are required by an executive manager and could be on the check request, on the invoice or on a contract that is attached to the check request. After further review, we found that all the check requests are properly approved.

- The "expenses" referred to were actually accrued expenses and not actually cash disbursements; therefore, no checks were issued.

- After further review of all the requested expenses, we could not determine which two expenses were not properly posted to the GL. All entries are posted to the GL.

- Chartered's standard practice is to stamp invoices as paid. However, if one invoice was not stamped properly, the accounting system (ACCPAC) will not allow the invoice to be paid twice. This is clearly a valid and operating mitigating control.

Findings:

In the course of its response to the Report on Examination of the Effectiveness of Internal Controls over Financial Reporting, Chartered has addressed in some detail, the auditor contention that Chartered's affiliated entity transactions where not at arms length. As such, there is no need to further expound on those issues here. Chartered would note, however, that these findings do not relate in any way to the engagement questions outlined on page 1 of this report. None of these findings addresses the issue of disparities in capitation payments between the MCOs with the total amount paid to health care providers. None of these findings address whether legitimate medical services are being charged to medical costs. The internal control issues with respect to reporting of claims and encounter data is fully addressed by Chartered. While citing the need to improve Chartered's ability to address fraud, the report misses significant aspects of Chartered's Compliance program and wrongly states that it has no ethics policy or whistleblower hotline when clearly it has both and has had them for years. It would appear that rather than address the areas of concern to the Council, the auditors have embarked upon an effort to determine how Chartered spends that portion of its at risk actuarially determined capitation payment that is totally within its province.

Furthermore, the approach utilized by the auditors to determine what constituted a potentially excessive expense was based solely upon the auditor's estimate of the fair value, without regard to the analysis and other information sources made available by Chartered, resources available at MAA, resources available at the other MCOs, resources available from the marketplace, and other public resources from which health care can be obtained. Therefore, the findings of the $7,679,964 of related party expenses that the auditor "felt" appeared potentially excessive and unsupported is not accurate, unnecessarily subjective and fundamentally flawed, especially in light of the absence of any significant managed care organization experience within the auditor group. Chartered does not agree with this finding.

With regard to the comments in the Legend footnotes, Chartered Health Plan Responses as follows:

Response to (a)

CFHC is a multi-specialty, freestanding clinic that provides services that are significantly more than provided by PCPs. CFHC's services are comparable to the services provided by Federally Qualified Health Centers (FQHC). While CFHC is not a FQHC, it serves many of the same functions and many more services to CHP members who frequent it. For example, according to the Rural Assistance Center of the Department of Health and Human Services FQHCs provide the following services:

"FQHCs must provide primary care services for all age groups. FQHCs must provide preventive health services on site or by arrangement with another provider. Other requirements that must be provided directly by an FQHC or by arrangement with another provider include: dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care."

These services are comparable to the services provided at CFHC.

It is well recognized that FQHC rates and PCP rates differ and that FQHC rates are substantially higher. For example, in a recent report from the Center for Health Program Development and Management, the data company for the Maryland Medicaid Program reports that the range of rates for FQHCs is $95.16 - $200.62 and, for the same period, the range for PCPs is $31.90 - $43.41. Effectively, rate comparisons of CFHC and PCPs are not appropriate because the scope of services is not comparable.

To establish CFHC full risk capitation rates, CHP utilized comparative data for market rates of FQHCs in the surrounding area and in comparable cities and current financial exposure from the pending $60 million law suit. For example, to set the current rate of $49.44 PMPM, CHP reviewed the market rate for FQHCs in the surrounding area: Washington, DC and Maryland. It also compared FQHC in the surrounding area and the federal government, and also compared FQHC rates in other regions. A chart entitled "Health Center Reimbursement," which is found on page 14 provides an illustration of the respective per visit costs and capitation rates. In every instance, CFHC's rates compare favorably and reflect fair market value. Chartered also provided the auditors with a copy of the 2005 Medicaid Annual Report, which at page 23, provides the DC Medicaid payments on a per member per month basis. This report revealed that the District pays the FQHCs on a PMPM basis almost 4 times the amount Chartered pays CFHC. See also page 15 above.

Response (b)

Although Chartered includes the Health Education expenses in the Medical expense for accounting purposes, the cost of the program is paid from Chartered's administrative expense and is not included in the medical cost component of Chartered capitation payment. It, therefore, falls out of the scope of this engagement. However, the payment was developed and provided to the CFHC so that they could deliver Health Education services to all of Chartered's members even those that are not assigned there for primary care because of the current location of CFHC to the last number of Chartered's members who reside in Wards 7 and 8. These rates were developed by Chartered using market rate comparisons.

Response (c)

As demonstrated to the auditors on several occasions and explained above in this response, the capitation rate paid to RapidTrans is reasonable and based on comparable

market rates for non-emergent Medicaid transportation. To determine rates for RapidTrans, Chartered assembled comparative market data for non-emergent Medicaid transportation. As part of that analysis, shared with the auditors, Chartered compared the District, Maryland, Virginia, Delaware and US rates for non-emergent Medicaid transportation for the year 2001, the most recent data available. That analysis revealed that the RapidTrans rate was also at or below rates from unrelated entities for similar services. Significantly, the RapidTrans rate is almost ½ the non-emergent transportation expense for the Medicaid population in the District on a PMPM basis during 2005.

In addition, the comparison used by the auditors assumes that Chartered members could take taxi rides at an average cost of $19 per one-way trip. First many Chartered enrollees live in areas of the District that are not conducive to taxi service. In these areas, taxis do not come when called and are consistently reluctant to go to these areas when hailed. Second, as indicated above, Chartered members are challenged to get to pick-up points in a timely manner, and taxis would not wait or return to pick them up as RapidTrans does. Third, as indicated above, many members bring more children with them than can fit in a taxi safely and most taxis would not have enough child safety seats to meet the needs of our members and comply with District law.

Response (d)

At the outset, it should be understood that with respect to the contention that the Chairman of Chartered charged any time to the consulting activity performed by TCBA for Chartered, Chartered states that this is inaccurate and would request the source of this contention by the auditors.

The primary concern here again is whether the transaction between Chartered and TCBA is an arm's length one. An arms length transaction is one in which the charge to the organization is in line with the charge for such services, facilities, or supplies in the open market and no more than the charges made under comparable circumstances. Note 5 (d) of the 2005 financial statements audited by KPMG states, "Chartered paid TCBA $238,827 during 2005 as a reimbursement for its actual labor costs plus overhead and general and administrative costs calculated at TCBA's approved federal government GSA overhead and general and administrative rates, without profit markup to TCBA."

Chartered provided the auditors with the General Services Administration (GSA) Schedule that was used to determine the market rate for consulting services like the services TCBA provided to Chartered. The GSA establishes a schedule for various services, including Management, Organizational and Business Improvement Services (MOBIS). The MOBIS reflects the rates the entire Federal government is willing to pay to obtain consulting services similar to the services provided by TCBA to Chartered. Since the entire federal government and most local governments are willing to accept the MOBIS rates, Chartered submit that such rates reflect appropriate rates for the open market. An examination of the MOBIS schedule will reveal that the rate that was charged by TCBA is at or below the rates charged the federal government for the identical services. Consequently, appropriate verification of arms length procedures can

be confirmed by the use of the MOBIS schedule and the determination that TCBA's rates were at or below the market rates reflected in such schedule. These rates are also less than other managed consultants retained by Chartered whose fees are indicated elsewhere in this response. See page 6.

Chartered Health Plan would also note that the quality of the services provided were evidence by the significantly improved audit results that the Alliance program received following the provision of these services by TCBA. The consultants resolved the enrollment problems that had been plaguing the Alliance program for several years. Reports of the work performed by TCBA were made available to the auditors. Therefore, we do not agree with their contention that the services were not performed.

Response (e)

As indicated above, the auditors saw no evidence that the lease agreement was an arms-length transaction because they did not ask for it from Chartered. Had they asked, Chartered would have provided them with what they were paying for their space in 2003 at the time that they decided to move as well as the proposed much higher fair market value of space at other locations that was identified by CB Richard Ellis, Chartered Commercial Real Estate Broker and that was visited by Chartered's management to determine suitability. This information remains available. Please see page 6 for a more detailed response.

Response (f)

Chartered Health Plan and DCHSI continued their management and consulting agreement through a Memorandum of Understanding (MOU) executed on April 15, 2003. A copy of the agreement was provided to the auditor. This MOU was superseded by the formal amendment of November 8, 2006, drafted by our attorney. In addition, Chartered provided the DCHSI Management Fee and Pass-Thru-Cost Reconciliation for the Year Ended December 31, 2005 to the auditors. To further document the $1.8 million expenditure, Chartered provided all of the invoices and supporting documentation. The service performed is explained in the time billing summary of the respective professionals. Some documents were identified as confidential, but were made available at the offices of Chartered for the auditors' review. They never requested to review these documents.

It should also be noted that the consulting rates paid by Chartered to DCHSI were at or below fair market value and that Chartered received good and valuable services and the results generated is very evident of this fact.

There is no (g).

Response (h)

No response required.

Response (i)

This finding is not accurate. As we demonstrated to the auditors, Chartered has a reasonable and established method of allocating any cost for services rendered by Chartered to its affiliates. This process was documented and covered in a Memorandum of Understanding (MOU) dated January 23, 2003.

Based on this MOU, in 2005, Chartered billed RapidTrans $45,169.48. Also, in 2005 Chartered billed Chartered Family Health Center $73,335 for administrative and accounting functions, in accordance with Chartered's formal methodology for allocating costs to affiliates. Moreover, the Human Resources budget includes addition items such as the cost for summer interns that are not charged to the affiliated entities.

Response (j)

As Chartered advised the auditors, there is no support for these expenses because they were charged back to DCHSI and therefore, these expenses were credited to Chartered and not included in the respective account balances.

Response (k)

With all due respect, Chartered disagrees with this assertion. This is another example of the auditor's lack of familiarity with managed care. Chartered has the highest number of HIV/AIDS members of all three managed care organizations (MCO), and as a good and responsible corporate citizen of the Washington, DC community, Chartered makes reasonable contributions to local non-profit organizations, particularly those who serve and represent our members. These contributions are made from Chartered's administrative costs. The specific non-profit organization cited by the auditors, Whitman-Walker Clinic, is the premier provider of services to individuals who have been diagnosed with HIV/AIDS, many of whom are members of Chartered Health Plan. Had the Whitman-Walker Clinic closed its doors and its Max Robinson Clinic in Anacostia, Chartered's members would have to resort to more costly treatment or none at all. Such costs would directly, and negatively affect the medical costs of Chartered, the other MCOs and the District.

DC Chartered Health Plan, Inc.
Response to Audit of Internal Controls
Appendix A – Reportable Conditions Related to Information Technology

The following represents our response the audit findings on internal controls related to information technology. We have not repeated the findings; however, in order to ensure coherence, we have shown the finding number and the related bullet. Where necessary and warranted, Chartered will review its controls and enhance them.

Objective		
#	Bullet	Response
1	1 - 4	The IS dept. is notified of a termination by the Human Resources Dept. The Human Resources dept. is responsible for collecting all equipment issued by the IS dept. The HR dept. is sent a copy of all signed documents that relate to cell phone, lap tops etc. at the time of distribution.
2		Chartered has worked extensively on the all aspects of the HIPAA regulations. To aid in the compliance of these regulations, Chartered considers all data in MHC to be PHI. Therefore, all employees sign confidentiality agreements at their time of hire. The IS dept grants security access to our MHC system based on their role and job function. Each request is approved by their supervisor prior to granting access. The systems security logs were provided to the auditors.
3	1	In order to show that systems are periodically reviewed, we demonstrated the process and provided screen prints to Millco while they were on site. Chartered acknowledges that a formal log of these reviews is not kept and is working on updating the process to include an on-going log.
3	2	All hard drives are removed from equipment at the time of disposal. All hard drives are kept locked down with minimal IS staff access. We are currently working on ways of destroying and disposing of hard drives. Chartered has considered the risk associated with this method and has made a conscious business decision to continue in this manner while researching a permanent method of disposal. If a proper risk analysis were completed, this would show minimal security risk.
3	3	As explained during Millco's on-site audit, upon initial login process, all users are told that password must be a minimum of 6 characters long, expire every 45 days and the password must be changed at least five times before it can be reused. Users are made aware of this at New Employee Orientation, as well as the first time they log on to their systems.
3	4	Chartered has made a conscious business decision that, because the MHC system resides on the internal side of the firewall, logging into UNIX, UniVerse, and MHC is only accessible by gaining Network access.

Objective		Response
#	Bullet	
3	5, 6 & 7	The termination of access to the Network is a priority for Chartered. Once access to the network is terminated, all access to internal databases is, in effect, also terminated. This was discussed extensively with the auditors and is deemed low risk by Chartered.
3	8 i	As explained during Millco's on-site audit, upon initial login process, all users are told that password must be a minimum of 6 characters long, expire every 45 days and the password must be changed at least five times before it can be reused. Users are made aware of this at New Employee Orientation, as well as the first time they log on to their systems.
3	8 ii	Chartered has made a conscious business decision to set the account lock-out duration to 60 minutes. The recommended Windows setting for account lockout duration and password complexity do not have an effect on Chartered's Network security.
3	8 iii	DC Chartered has made a conscious business decision to not enforce logoff when logon hours expire because many users run overnight processes. Forcing logoff would kill these processes and could be a detriment to Chartered's business practices. Instead of this practice and to ensure system security, **Chartered does enforce a screen saver policy that requires authentication after 5 minutes of inactivity.**
3	9	The accounts for FaxServer and ExchSrv are used for Windows services and are not traditional log-ins. This was discusses with Millco in detail while on-site. The account for Fax UM is used by our UM department to receive faxes. The UM staff has access to the mailbox ONLY and do not know the password for the user. This account will never show as being logged in. This was explained to Millco in detail while on-site.
3	10	As explained during Millco's on-site review, Oracle is not used as an application server. There is no data entered into Oracle; it is simply used for reporting purposes. Thus, activating an audit trail would be ineffective and would not show any unauthorized access.
4	1	The auditors were given, while on-site, a policy and documentation demonstrating that the Windows systems (desktops, laptops, servers) are patched through Microsoft Windows Server Update Services, as needed/recommended. Chartered has made a conscious business decision to use Oracle for our data warehouse. Oracle is not supported as a traditional database because it is behind our firewall and requires a secure login into the Windows network gain access, mitigating the risk.
4	2	DST Health Solutions (DST) provides information on patches and updates necessary to the UNIX platform and UniVerse database on which it MHC resides. Applying patches not recommended by DST can disable our Production Server and the software it supports.

Objective #	Bullet	Response
6	1	Chartered discussed and provided extensive documentation to the Millco auditors while on-site detailing the implementation plan, test documents, and control change forms for identified problems during testing for the implementation for the most recent version upgrade of MHC. Chartered does not own the source code so all process during this implementation are a joint effort between Chartered and the vendor, DST. Because we do not own the source code, we can not make any changes to the MHC system. In addition, DST Health Solutions (DST) performs all release updates and enhancements to their MHC software. Any updates that DC Chartered can perform are driven by requests from DST.
6	2	Chartered discussed extensively and provided documentation to the auditors while on-site, detailing the auditing that is done on ALL PC's connected to the DC Chartered network. DC Chartered audits PC's for hardware as well as software. If unauthorized software is found it is immediately removed from the PC. DC Chartered agrees that although this process is done and no unauthorized software is supported that this process is not formally documented. The IS dept. will formally document this process.
7	1	Although Oracle password controls are not fully implemented within Oracle, any security risk is mitigated by the fact that Oracle is behind a firewall and you must login into the Windows network to access it. Chartered has made a conscious business decision to implement passwords in Oracle with minimum controls enforced due to the mitigated risk because of its network location. We are currently researching single sign on control for all our systems but until we purchase such a system, these controls would only confuse the user and not make this system any more secure. Also, password control cannot be enforced in Oracle because DC Chartered staff access the database through an ODBC connection. Changing passwords through ODBC connection on Oracle DOES NOT WORK. If a password is set to expire the user would not be able to change their passwords. This was discussed extensively with the auditors during their on-site review.
7	2	All accounts are set to User and Temp table space because Users only have Select (query) access to Oracle. In order for users to query a table they MUST have access to the table space. The reasoning for individual table space would not apply in this scenario. This was discussed extensively with the auditors during their on-site review.
7	3	DC Chartered is operating on HP-UX 11i, which was and remains one of the most recent HP-UX releases, as approved by DST Health Solutions, during the most recent upgrade. Hewlett-Packard's HP-UX and Informix's/IBM's UniVerse database run without problem. However, running in trusted mode has caused conflicts between the two. Trusted mode is being considered and will be implemented for MHC Version 20, if recommend by DST Health Solutions.
7	4	Administering UNIX and UniVerse on the same server requires two root-level logins (root and uv).

Objective #	Bullet	Response
7	5	As the result of previous audits, following delineation of work was improved by created logins based on tasks/areas of work for employees rather than one per employee. The logins incorrectly noted as duplicates have not been removed.
7	6	We do not understand the nature of this finding.
7	7	Passwords are enforced on both UNIX and UniVerse. A user must have a login id and password for both UNIX and UniVerse, respectively, to access MHC.
7	8	The 5 R commands that are noted were not discussed.
7	9	The TFTP process that is noted cannot be located. Please specify.
8		The Senior Pick Programmer/UNIX System Administrator answers directly to the Senior Director and Vice-President of Information Systems. The job functions described and performed as the Senior Pick Programmer require passwords and logins that are separate for those utilized for UNIX System Administration functions.
10	1	Chartered has contracted with a vendor to continue development of our draft disaster recovery plan.
10	2 & 3	Chartered continually reviews all security policies and procedures and makes updates when deficiencies are identified. In addition, we are audited annually by an outside firm for compliance with security, as it relates to Chartered's data and financial implications. All audits are thoroughly documented.
10	4	MHC is a nationally recognized claims processing software. We first implemented their software in 1999 and have been using it successfully for years without any issues or concerns. We do not believe it is necessary, nor do we have the capability, to perform a certification and accreditation of the MHC application. Specifically, MHC is a DST Health Solutions product and the company and its software applications have been recognized as follows: ▪ 7 of "Top 10 Health Plans" rated MHC best for member satisfaction (NCQA) ▪ DST is one of the top 100 leading IT companies, *Healthcare Informatics* ▪ DST received the Pinnacle Award **for Best Practices**, Consumer-Directed Healthcare ▪ DST received the Frost and Sullivan Leadership of the Year Award for **excellence in meeting customer needs**, identifying new markets, introducing new products/services
11	1	During the on-site review, we discussed the Business Impact Analysis that was completed in 2001. We supplied the auditors with several copies of the individual assessments that were completed.
11	2	The testing of our backup tapes is documented in DC Chartered Health Plan's Disaster Recovery Plan. Also, DC Chartered has recalled tapes from our offsite storage and successfully restored data from the tapes on several occasions and has never run into a situation where a backup restore failed or we were unable to retrieve a necessary tape.

Objective		Response
#	Bullet	
11	3	First Federal facilities were evaluated by DC Chartered and found to be properly protected against most natural disasters. However, with the ever changing environment, Chartered recognizes the current systems limitations and is in the process of evaluating other, more advanced back-up systems in an effort to secure an out of state location for our data.
11	4	DC Chartered has installed a dry fire suppression system and is in the process of capping the wet pipe sprinkler system.
11	5	The unavailability of Windows and Novell do not substantially impact the recovery of MHC. In order to access MHC an additional method to enter the network would need to be developed. However, our vendor, DST would be able to connect and assist in any way needed.
11	6	We have identified and contracted with another vendor, Sungard, to assist us with a hot-site in case of the need for disaster recovery. Therefore there is no need for a contract with the health center for this need.
11	7	First Federal facilities were evaluated by DC Chartered and found to be properly protected against most natural disasters. However, with the ever changing environment, Chartered recognizes the current systems limitations and is in the process of evaluating other, more advanced back-up systems in an effort to secure an out of state location for our data
11	8	The fire extinguishers in the computer room are operational. Chartered has contracted with a fire protection company to inspect and maintain all of Chartered's fire suppression equipment, as required by DC law. Inspections are at maximum six months intervals.

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June 8, 2007
Mr. Robert T. Maruca
Senior Deputy Director
Department of Health
Medical Assistance Administration
Government of the District of Columbia

Dear Mr. Maruca:

We have reviewed D.C. Chartered Health Plan, Inc.'s response to our report on the examination of the effectiveness of internal controls over financial reporting and our report on the review of operating expenses of its contract with the District of Columbia Department of Health. It is our view that Chartered's response failed to directly address the concerns cited in our report and its management fails to accept that our findings are legitimate. This response raises additional concerns inasmuch as management of Chartered can not begin to address the deficiencies cited until they accept responsibility for the deficiencies and agree to a corrective action plan.

We continue to firmly stand by our report and have provided specific responses to Chartered's responses to our report. Our responses are as follows:

Material Weaknesses

We cited that Chartered had material weaknesses in its internal control system. Chartered disagreed and cited the following reasons:

1. Our team is inexperienced in these type of engagements
2. Chartered had been audited by KPMG, which did not cite any material weaknesses.
3. All related party transactions were conducted at fair market value
4. Chartered's contract with the District is a risk based contract and the concerns cited regarding administrative services are of no concern to the District.
5. Chartered is a privately held company and only the owner should be concerned about transparency and disclosure of related party transactions.

Our response is as follows:

1. We have provided the District evidence of our qualifications to perform this engagement. Furthermore, the material weaknesses noted were not concerns specific to MCOs. The two major concerns cited dealt with unsupported related party transactions and weaknesses over its information systems. These are areas affecting every industry and have major concerns as areas of common abuse.
2. Chartered's audit by KPMG was of a different scope and for a different purpose than our engagement. KPMG was engaged by Chartered to express an opinion that the financial statements fairly presented Chartered's financial position and operating results in accordance with Generally Accepted Accounting Principals. The primary interested party in KPMG's audit is Chartered's owner. Therefore, KPMG's focus on materiality was most likely based on Chartered's reported income. Also, KPMG's testing of internal controls was much more limited than our testing. Our review focused on determining if Chartered's internal controls were adequate to ensure transparency and accuracy in its reports to the District. We feel that the reports to the District

lacked transparency and have the potential to be misleading by amounts that could materially influence the District's capitation negotiation process. Therefore, we continue to feel that the weaknesses cited are material.

3. Chartered did not demonstrate that their related party transactions were at fair value. Our report cites clear examples where material amounts were charged to Chartered by affiliates in excess of amounts that could be supported. We have recently concluded our review of another MCO and compared its cost for the same type of services that Chartered acquired from related parties and noted that the other MCO was able to acquire the same services at a fraction of the cost paid by Chartered to its affiliate.
4. It is partially true that Chartered's contract with the District is a risk-based contract. Chartered does receive fixed capitations for its members from which it must provide medical coverage; however, the capitation rates that are negotiated are based on Chartered's reported cost to provide medical coverage. If the reported cost of providing medical coverage is inflated, it will generally result in inflated capitation rates.
5. Chartered's response about it being a privately held company would be legitimate if it were not receiving public funds; however, Chartered received all of its operating revenues from the District. For that reason and reasons cited above, the District has a vested interest in Chartered's financial reporting.

Transactions with Related Parties

Chartered disagreed with our findings and cited the following reasons:

1. Transactions with related parties are at or below fair value.
2. Chartered Family Health Center (CFHC) provides comprehensive services, over and above the services provided by other primary care providers.
3. Chartered agreed to cover the cost of a $60 million litigation in which CFHC is the defendant.
4. The $1.8 million paid to Chartered's parent was for consulting services rendered and reimbursement of debt service on a $3.5 million loan used for the acquisition of Chartered in May 2000.
5. Chartered prepared an analysis which revealed that the RapidTrans rates for transportation costs are at or below rates from unrelated entities for similar services.

Our response is as follows:

1. Same as our response to material weaknesses, above.
2. The contract between Chartered and its primary care providers, including CFHC, specifies the required level of service to be provided. We noted no significant difference in the services required between CFHC's contract and the contract of other primary care providers who are paid less. In their response, Chartered states that the CFHC employs doctors, nurses, receptionists, appointment and medical record clerks, and management and administrative personnel. Most, if not all, the providers would have similar type of staffing. As we stated in the findings, the capitation rate paid to CFHC is more than double the rates paid to any other primary care provider, the highest of which is $21.50 vs. $49.44 paid to CFHC. Chartered has indicated that CFHC costs are higher than other primary care providers, based in part on additional administrative and facility services provided above the minimum level, including specialty care such as ob/gyn, pediatric, and orthopedic. They also cited higher legal and administrative costs, even though the contractual requirement to provide service is the same for CFHC as any other primary care provider. The response also emphasized that CFHC provides primary and specialist services; however, it is our understanding that specialist services are billed on fee-for-service basis and should not be considered in the capitation rate. If specialist cost is in the capitation rate and also billed separately, Medicaid could be paying twice for the same service. Another reason offered by Chartered for the higher rate is CFHC costs includes costs relating to legal and administration, in particular, costs associated with a major legal proceeding. According to Chartered, these litigation costs were the responsibility of DC Healthcare Systems, Inc, the parent of Chartered, but allocated

in part, to Chartered. Furthermore, Chartered down streamed the liability of the lawsuit to CFHC. Such costs should be included in DC Healthcare Systems, Inc. legal and administrative cost. By including these legal/administrative costs directly in the cost of health care paid to CFHC, Chartered inappropriately includes these costs in its health care cost. If these costs were ultimately determined to be legitimate costs of Chartered they should be classified as legal/administrative cost, not health care costs. If the administrative costs in question were counted in Chartered costs, the administrative percentage could be above the maximum allowed.

3. See item two (2) directly above.
4. Chartered's contract with the parent company was not executed until after the year that the costs were actually incurred. Furthermore, the contract dictates that the payments would be based on invoices for services performed. We noted no invoices received and also noted that the amounts were paid in equal $150,000 monthly amounts. We noted no evidence of the services received. With respect to the reimbursement for debt services payments, we feel that such costs would be inappropriate for inclusion in capitation rate negotiation purposes. We continue to stand by this finding.
5. In a memo received from Chartered management, it noted that Chartered based their transportation "value" on information from LogistiCare, a company that provides Medicaid non-emergency services in the District of Columbia (DC). Therefore, Chartered adjusted the rate paid to its related party provider, RapidTrans, to a capitated rate of $5.35 per member per month (pmpm). We reviewed another DC Medicaid managed care organization (MCO) and noted that their contract with LogistiCare to provide non-emergent transportation services is based on a capitated rate of only $1.70 pmpm. Both Chartered and the other MCO have a comparable total Medicaid membership population of approximately 40,000. For a twelve-month period, the reported transportation cost for Chartered was $2,940,569 (this includes an adjustment for the prior year of about $490,000). For a twelve-month period of the other MCO, the reported amount was $813,591. This disparity is significant and should be justified by Chartered.

Weakness with Control Environment

Chartered disagrees with this comment and cites a number of conditions that they contend represents an adequate control environment; however, we contend that an adequate control environment would not have permitted the substantial unsupported related party transactions. We continue to stand by this comment.

Inadequate Controls over IT Functions

Chartered's response fails to directly address our findings. We continue to firmly stand by this comment.

SAS 70 Reports

Chartered indicates in their response that they will begin to ask their service processors to provide SAS 70 reports. We find that this response is adequate.

Chartered fails to Fairly Allocate Administrative Costs to Affiliates

Chartered's response indicates that our finding is not accurate. During our fieldwork, Chartered did not provide any documentation regarding administrative cost allocation policy. We did receive a copy of the $45,000 invoice related to a finance cost allocation but that invoice did not include any details relating to the calculation of salary cost and did not identify corresponding percentages of the employees' salary.

Our finding regarding administrative cost allocation relates to Human Resources (HR) and Payroll. During our fieldwork, we were told that 30-35% of HR/payroll hours are expended on affiliate activities for which we found no cost allocation.

Subsequently, we did receive a copy of the cost allocation policy. Nonetheless, at the time of our fieldwork,

we did not see any other administrative costs allocated to affiliates. Therefore, we were not able to determine if Chartered allocates cost to its affiliates as recorded in a policy.

Minimize Fraud and Inaccurate Provider Reporting

We understand that Chartered does have a Compliance Plan that was submitted and accepted by the District. We also understand that Chartered utilizes certain Ingenix software solutions.

Given the industry's high risk for waste, our finding relates to additional action that should be taken to prevent, minimize, and/or recover potential waste. For example, we had encouraged on-site reviews of providers billing records. In Chartered response to the findings, they have indicated that they now have a contract with a vendor to perform on-site audits.

Notwithstanding Chartered's Compliance Plan and their level of audit before claims are adjudicated, in 2006, Ingenix analyzed approximately three (3) years of claim data (11/06/2003-10/31/06) and reported to Chartered a number of findings with recommendations to recover potential incorrect payments thereby underscoring the need for additional fraud and abuse prevention measures. In fact, Chartered acknowledges this very point in the conclusion of their response to this finding.

Document formal Procedures for Data Extraction

Chartered's response indicates that they disagree entirely with this finding. Our concerns relating to this finding were discussed at length with Chartered's Internal Auditor and the personnel who had responsibility for data extraction. At the time that this concern was discussed, Chartered's management was "at a loss" to explain why they were getting different results from the various data extractions of supposedly identical databases. At that time, they agreed that they needed to document standard procedures for this purpose. We continue to stand by this comment.

Controls Should be Strengthened over Payments to Pharmacies

Chartered acknowledges in its response that it will enhance procedures where warranted and therefore, we continue to recommend that Chartered agree the bi-weekly wire transfer amounts paid to the detailed monthly reports for all payments made.

In addition, we recommend that Chartered confirm the rates used in payment processing to the agreed upon rates in the prevailing contract, and implement procedures to ensure that Caremark maintain adequate internal control over the drug benefit administrative process.

Certain Costs are Paid for and Paid to CHFC without Support

See comments above relating to costs paid to Chartered Health Family Center. Also, a depreciation expense item of $154,544 was included in the total reported capitation cost. We were informed that this was an expense applicable to CHFC; however, it is recorded in Chartered books as if it is an additional capitation cost. Based on the detailed depreciation expense report, the largest item relates to Leasehold Improvement and Leasehold Improvement-labor. The original cost being depreciated is $2,102,556. The details relating to the original cost was not attached to the depreciation information. Chartered failed to address this item in its response.

Number of Enrollees in Sub-capitation Arrangements Differs

Chartered's response indicates that they disagree with our finding but will review these processes and enhance the controls where warranted.

We continue to recommend that Chartered confirm the number of enrollees in all sub-capitation arrangements. The number of members per month used for non-PCP sub capitation vendors should be the same within a given month for all vendors with the same basis of member eligibility. Within our sample

months, the number of members per month was different for some vendors.

We inquired about the procedure and authorization for the monthly capitation payment and were referred to three (3) different departments without receiving satisfactory explanation.

Improve Controls over Payroll and Human Resources Departments

Chartered disagreed our comments and cited the following reasons which we have responded to below:

1. Chartered agreed then subsequently disagreed, citing that a secondary review is completed by the Payroll Accountant.

   During our review, we were informed that the Payroll Accountant is responsible for updating payroll related withholdings and deduction information. We noted no evidence of a secondary review performed by the Payroll Accountant. We continue to stand by this comment.

2. Chartered disagreed, citing that Chartered's HR policies and procedures are contained in its Employee Handbook.

   Our finding relates to specific procedures to be performed by HR personnel to ensure that the critical HR functions are completed accurately in the event of HR personnel absence. The Employee Handbook does not accomplish this function. We continue to stand by this comment.

3. Chartered disagreed, citing we observed HR personnel access ADP Perspectives (HR information system) as opposed to ADP Payroll (Payroll processing system).

   We observed as the HR Specialist clicked on "start" on her Microsoft Windows Operating System, and then viewed all programs listed which included a folder of software programs related to ADP. Within the ADP folder there were several different software options that included ADP Perspectives and ADP Payroll. ADP Payroll was selected, a user login and password was entered, and access was granted. We continue to stand by this comment.

4. Chartered disagreed, citing their mitigating control to prevent fraud or errors is payroll payees cannot be created in the payroll system by Payroll Accountant or by a Department Head.

   We requested a system generated user list for the payroll system that was not provided; therefore, we were unable to confirm who has access to payroll system. Additionally, based on number three (3) directly above, we question who has access to Chartered's ADP related software systems. We continue to stand by this comment.

5. Chartered disagreed, citing that payroll summaries are reviewed by the Director of Finance and the CFO reviews total payroll and payroll expenses for variances.

   Our finding relates to reviews completed by the Director of Finance or the CFO for every payroll period. Chartered's response does not identify how the Director of Finance or CFO reviews are documented. We continue to stand by this comment.

6. Chartered disagreed, citing that signed payroll wire transfers are maintained by Chartered's Chairman and a copy of the unsigned wire request is maintained by Chartered.

   Chartered maintaining a copy of an unapproved wire request does not constitute complete records being maintained at a centralized location. We continue to stand by this comment.

Improve Controls over Cash Disbursements

Chartered disagreed with our remaining comments and cited the following reasons which we have responded to below:

1. Chartered did not pay the five (5) expenses in question and they are not included in Chartered's Financial Statements.

   After discussion with Chartered's management and review of supporting documentation, we no longer consider this a finding.

2. The auditors did not ask for 31 journal entry batch listings noted as not received.

   Our request was sent to the CFO on March 1, 2007. We continue to stand by this comment.

3. After further review, Chartered found that all check requests are properly approved.

   During our review, we reviewed check requests and supporting invoices for proper approval. We continue to stand by this comment.

4. The "expenses" referred to were actually accrued expenses and not actually cash disbursements; therefore, no checks were issued.

   We agree that the expenses represent accruals; however, the accruals resulted in a related cash disbursement in the subsequent month for which no check was received. We continue to stand by this comment.

5. After further review, all entries were properly posted to the general ledger.

   We noted for one check request that the general ledger posting instructions per the check request did not agree to the actually posting per the general ledger. For a different expense, we noted a contribution was recorded as a capitations payable, as opposed to accounts payable. We continue to stand by this comment.

6. If an invoice is not stamped properly, the accounting system will not allow the invoice to be paid twice.

   Due to the untimely receipt of our requests, we were not able to obtain evidence that Chartered's accounting system will reject payment due to duplicate invoice. We continue to stand by this comment.

We hope this response adequately addresses any concerns that you may have with Chartered's response to our reports.

Sincerely,

John Milligan

John Milligan, CPA, Managing Partner
Milligan and Company, LLC